Exhibit A

STATE OF WISCONSIN CIRCUIT COURT DANE COUNTY
----------X
STATE OF WISCONSIN, : CASE NO.
Plaintiff, : 04-CV-1709
v. :
AMGEN INC., et al., :
Defendants. :
----------X

IN THE COURT OF COMMON PLEAS
FIFTH JUDICIAL CIRCUIT
----------X
STATE OF SOUTH CAROLINA, and : STATE OF
HENRY D. McMASTER, in his official : SOUTH CAROLINA
capacity as Attorney General for : COUNTY OF
the State of South Carolina, : RICHLAND
Plaintiff, :
v. : CIVIL ACTION:
MYLAN LABORATORIES, INC. : 07-CP-40-0283
Defendant. :
----------X

IN THE COURT OF THE SECOND JUDICIAL CIRCUIT
IN AND FOR LEON COUNTY, FLORIDA
THE STATE OF FLORIDA
ex rel.
----------x
VEN-A-CARE OF THE FLORIDA :
KEYS, INC., a Florida :
Corporation, by and through its :
principal officers and directors, :
ZACHARY T. BENTLEY and :
T. MARK JONES, :
Plaintiffs, :
vs. : Civil Action
MYLAN LABORATORIES, INC.; MYLAN : No.: 98-3032G
PHARMACEUTICALS INC.; NOVOPHARM : Judge:
LTD., SCHEIN PHARMACEUTICAL, INC.; : William L.
TEVA PHARMACEUTICAL INDUSTRIES : Gary
LTD., TEVA PHARMACEUTICAL USA; :
and WATSON PHARMACEUTICALS, INC. :
Defendants. :
----------x

IN THE CIRCUIT COURT OF THE CITY OF ST. LOUIS
STATE OF MISSOURI
----------x
STATE OF MISSOURI, ex rel., :
JEREMIAH W. (JAY) NIXON, :
Attorney General, :
and :
MISSOURI DEPARTMENT OF SOCIAL :
SERVICES, DIVISION OF MEDICAL : Case No.:
SERVICES, : 054-1216
Plaintiffs, : Division
: No. 31
vs. :
DEY INC., DEY, L.P., MERCK KGaA, :
EMD, INC., WARRICK :
PHARMACEUTICALS CORPORATION, :
SCHERING-PLOUGH CORPORATION, and :
SCHERING CORPORATION, :
Defendants. :
----------x

New York, New York
Friday, May 4, 2007

Videotaped Deposition of BRUCE C. VLADECK, Ph.D., a witness herein, called for examination by counsel for Abbott Laboratories in the above-entitled matter, pursuant to Subpoena, the witness being duly sworn by JOMANNA DEROSA, a Notary Public in and for New York, taken at the offices of Jones Day, 222 East 41st Street, New York, New York, at 8:38 a.m. on Friday, May 4, 2007, and the proceedings being taken down by Stenotype by JOMANNA DEROSA, and transcribed under her direction.

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Q. And for a brand name drug, would you -- at the time, did you expect that there would be much variation between various purchasers based upon volume purchases of the brand name drug?
A. I believe we had a perception that the bigger the purchaser, the larger the discount they were likely to be able to achieve; that the very largest pharmacy chains, for instance, or hospital group purchasing operations, probably received the most favorable prices, but that that would be -- and that some small independent pharmacies might actually pay average wholesale price as described in the compendia; that there would be a range below that in which most of the prices would actually occur.
Q. Turning to generic drugs for a minute, what do you understand to be the differences between the market for brand name drugs and the market for generic drugs?
MS. BROOKER: Objection. Form.
A. If we're going back to 1997 --
Q. Correct.

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A. -- I think it's fair to say that I had really only a very limited understanding of the marketplace for generic drugs and an even more limited understanding of the difference between the market for generic drugs and for brand drugs.
And, again, my perception at the time was that that was likely more like a commodity market in which there was probably more purchasing power on the part of the large purchasers, but not the same ability to raise prices on the up-side to small purchasers that prevailed on the brand name side.
Q. I'd like to focus you just for a minute, before we turn to a specific document, about a particular generic drug. I think you mentioned commodities. Are you familiar with sodium saline solution?
A. Yes.
Q. It's a bag of salt water, essentially. Correct?
A. That's correct.
Q. Would you agree with me that you can't

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get much more commoditized in a bag of salt water in the drug market?
A. The only quibble I would provide to that question is I never really thought of it as classically being part of the pharmaceutical market. It was such a -- it was really a hospital supply kind of market. It was such a standard product that even though it was FDA regulated and -- and sterility issues were so forth, it tended to be -- hospitals tend to stock it, for example, in sterile supplies, put it on their cost report as part of sterile supplies rather than through their pharmacies.
Q. But a home infusion provider reimbursed under Part B, for example, might be reimbursed for sodium saline solution.
Was that your understanding in '97?
MS. BROOKER: Objection. Form.
A. Yes, but whether that was as a supply or a drug, I honestly couldn't tell you. I would have thought of it as a supply.
Q. Turning to the market of it, whether we

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call it a drug or -- or a supply, did you have an understanding, in 1997, of what the market would look like for a product such as sodium saline solution?
MS. BROOKER: Objection. Form.
MR. BREEN: Objection. Form.
A. Yes, I did.
Q. And what was your understanding?
A. Well, I actually -- in the 1980s, I believe, when I was first becoming involved in some of these issues in health care economics was the first development of hospital group purchasing operations, and I recall -- and the first widespread circulation of the -- of "Modern Healthcare," the magazine, and I recall monthly headlines in "Modern Healthcare" about group purchasing operations being -- achieving discounts of 98 and 99 percent in their purchase of basic infusion products and sterile supplies.
So, my perception was that on the supply market, which, again, I understood and still would contend is actually a separate market

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from the pharmaceutical market that list prices, are essentially entirely meaningless and that only the weakest and smallest scale buyers pay anything close to it.
Q. And so, as of 1993, for example, would you be surprised if a single bag of sodium saline solution sold to a provider who bought maybe five would pay $10 per bag, and a large purchaser who bought a very large volume would pay less than a dollar?
MS. BROOKER: Objection. Form.
A. I would not have been surprised.
Q. Okay. So, to that extent that -- President Clinton referring to a 10-to-1 ratio is something that would be consistent with your understanding of that particular market. Correct?
MS. BROOKER: Objection. Form.
Q. I'm sorry. You have to verbalize.
A. Again, I would have thought that market was a subset of the supplies market rather than the drug market.

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Q. That was my question. But you would have distinguished between the drug market, where 10-to-1 would not -- you would not expect to see. Correct?
A. That's correct.
Q. And the supply market, where sodium saline solution would be found, where there could be a huge variation between a small purchaser purchasing at list price and a very large purchaser purchasing at 99 percent off of list price?
MS. BROOKER: Objection. Form.
A. I would have made such a distinction, and I would not have been surprised to see those sorts of differentials of the supply market.
Q. And in between the commodities supply market of sodium saline and the patent-protected market of a brand name drug, would you expect generic drugs to be somewhere between those two extremes?
MS. BROOKER: Objection. Form.
MR. BREEN: Objection. Form.

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A. That would be a question I never thought about before today. But today I would say that we always made the distinction between -- between drugs and -- and supplies. And, again, I would fall back on the Medicare green eyeshade distinction between what's sterile supplies and what's pharmacy.
MR. COOK: Let's take a break.
THE VIDEOGRAPHER: The time is 11:28 a.m. We're going off the record, concluding Tape No. 2 in the deposition of Dr. Bruce Vladeck in the matter of In re Pharmaceutical Average Wholesale Price Litigation.
(Recess taken.)
THE VIDEOGRAPHER: The time is 11:46 a.m. We're going back on the record, starting Tape No. 3 of the deposition of Dr. Bruce Vladeck in the matter of In re Pharmaceutical Average Wholesale Price Litigation.
Q. Doctor, based upon what we were talking about just before the break, would it be fair to say that while you were administrator of HCFA,

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you did not understand published average wholesale price to be the average of prices at which wholesalers were selling their drugs to their customers?
A. It would -- it would be fair to say that I did not believe it was, in fact, an empirical estimate, that rather it was a -- an amount reported by the manufacturer to -- of the compendium compilers or whatever, yes.
Q. And, again, akin to a sticker price?
A. That's correct.
Q. Where did you get that understanding?
A. I believe that was probably what my staff explained to me when I first encountered the concept sometime after I took office.
Q. Do you recall anybody within HCFA who was under the belief that average wholesale price was an average of prices at which wholesalers sold drugs to customers?
MS. BROOKER: Object to form. And I would just instruct the witness, just, you know, be mindful of not disclosing deliberations,

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facts from OIG in the form of an OIG report?
MS. BROOKER: Objection. Form.
A. You'll have to ask -- I don't know quite how to answer that question. I don't know if you want to rephrase it, but --
Q. I'm happy to. It -- it was -- it was a bad question. I can break it up into little -- little bites.
HCFA would receive facts from OIG, correct, in the form of these reports?
MS. BROOKER: Objection. Form.
A. Yes.
Q. As the administrator of HCFA, you had an expectation that your employees would consider facts presented to the agency for what they were; whether true or -- or false. Correct?
MS. BROOKER: Objection. Form.
A. Yes, absolutely.
Q. Okay. Did you rely upon the OIG, in its reports, to represent accurate facts to your agency?
A. We -- we had a moderate degree of

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confidence in the reliability of the information they presented.
Q. So, sometimes the information would be inaccurate. Correct?
A. That's correct.
Q. And you expected your staff to at least attempt to distinguish between the good data and the bad data that came from OIG in these reports. Correct?
MS. BROOKER: Objection. Form.
A. I -- I think it would be more -- more usual to object by -- to the methodology by which the facts were presented or the facts were obtained or presented than arguing about a specific number or something of that sort.
Q. To the extent that the facts appeared to be reliable as they were presented to HCFA, did you have an expectation of whether or not your staff would consider those facts in developing policy within the administration?
MS. BROOKER: Objection. Form.
A. Well, that's -- that's the complicated

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part of your earlier question of this one because the Inspector General demonstrated a pretty consistent proclivity to document instances in which policy was producing untoward results or excess expenditures or so forth, even though we believed, and they were aware that we had no discretion to make any changes in them.
Q. Okay. So, to the extent that you were able to make policy changes, did you expect your staff to take into consideration those facts in formulating policy changes?
A. Absolutely. Yes, sir.
Q. And to the extent the policy changes required legislation from Congress, did you expect your staff to take these facts and factor them into recommendations to Congress for policy changes and legislation?
A. Yes.
Q. In that context, I'd like to look at the particular purported facts at least that are reported in Appendix 2 of Exhibit Abbott 082. You'll see it's a -- it's a table with a fairly

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large number of numbers on it.
Now, it says:
"Invoice Price For Selected Drugs At the Dialysis Facilities Reviewed."
And in the left-hand column, can you see it has three drugs, Calcigex, Inferon, and vancomycin?
A. Yes.
Q. Do you know what Calcigex, Inferon, and vancomycin are?
A. I know what vancomycin is. I'm not familiar with the other two.
Q. Okay. Tell me, what is vancomycin?
A. Vancomycin is a fourth generation broad-spectrum antibiotic.
Q. And in 1992 it was a multiple-source product. Correct?
A. I don't know.
Q. If you can see on this chart, at least OIG purports to represent, under each of Calcigex and Inferon, the "S" in parentheses, and then with vancomycin there's an "M" in parentheses.

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And in the footnotes, the "S" indicates, according to the OIG, that Calcigex and Inferon are single-source drugs, and that the vancomycin is a multiple-source drug.
Do you see that?
A. Yes, I do.
Q. Okay. Leaving aside knowing exactly when vancomycin went generic -- well, let me stop for a minute.
Is it your understanding that today vancomycin is generic?
A. Yes.
Q. Okay. And it's just a question -- you don't know when it went generic and when it went off patent. Correct?
A. That's correct.
Q. Okay. The array to the right of each of these drugs purports to be per-unit cost.
Correct?
A. That's my understanding of the table, yes.
Q. And it lays out a number of numbers.

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To the right-hand side there are two other columns or three other columns, but two in particular labeled "EAC" and "AWP."
Do you see that?
A. I do.
Q. EAC, at the bottom, is defined as:
"The estimated acquisition cost calculated using the median invoice price, according to OIG."
Right?
A. Right.
Q. And AWP is defined as:
"The average wholesale price being the median Red Book price for the generic form of the drug, or to the extent there's not a generic form, presumably the AWP for the only form of the drug."
Do you see that?
A. Yes.
Q. I'd like to focus first just on vancomycin.
You understand vancomycin is one of the

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drugs at issue in -- in this case. Correct?
A. Yes.
Q. And did you have an understanding of that before meeting with the Department of Justice or did you only obtain that when you first -- when you first started preparing for this deposition?
A. I only became aware --
MS. BROOKER: I would just instruct you to be mindful not to disclose any conversations you've had with counsel in this case. You can state what your understanding is.
A. I -- I became aware that vancomycin was involved in this case within the last few weeks.
Q. Thank you. Do you see that the AWP for vancomycin is reported by the OIG to be $19.17?
A. Yes.
Q. And the EAC has reported it to be $5. Correct?
A. That's what they reported, yes.
MR. BREEN: Objection. Form.
Q. So, that would appear to be a -- a

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ratio of about four -- just under 4-to-1 between what the OIG is reporting as the estimated acquisition cost and the AWP for vancomycin in 1992?
A. That's --
MS. BROOKER: Objection. Form.
A. -- that's what it shows, yes.
Q. And -- and, again, I realize that this is not a report that -- that you -- that -- that you saw or you prepared, but just to round out laying out the facts as they're relevant now and -- and later in the deposition, if you'll look for me at the array of prices for vancomycin in 1992, according to the OIG, you'll see that -- am I correct that the lowest invoice price discovered by the OIG in this report for vancomycin was $3.45? Correct?
A. That appears to be the case, yes.
Q. And the highest that the OIG reported to HCFA in 1992 was $26.61.
Correct?
MS. BROOKER: Objection. Form.

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A. That's correct.
Q. We were talking a little bit earlier about the -- the range of prices that a -- a commodity, a supply such as sodium chloride solution might have, being as much as 100-to-1. Correct? You recall that?
A. Yes.
Q. Okay. As to generic drugs, would it be consistent with your understanding, between 1993 and 1997, that a generic drug such as vancomycin could have a market range of prices as wide as that reflected in this chart?
MS. BROOKER: Objection. Form.
A. I am -- I think the most accurate way to answer that was I am surprised, as of today, to see that kind of data, and I think I would have been even more surprised, during the '93 to '97 period, to see that kind of data.
Q. But this is data that was reported to your agency. Correct?
A. That's -- that's my understanding, yes.
Q. And you would have expected members of

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your staff to have taken this data into account in either a -- and let's start with establishing Medicaid or Medicare reimbursement policy.
MS. BROOKER: Objection. Form.
A. I would have expected, given the nature of this report then, to have been much more influenced by the bolded section in the box on Page 2.
Q. And what aspect of that would you expect them to be influenced by?
A. Again, the finding that -- that most prices were, in fact, below the AWP, but that in two of the cases the differential was 15 to 20 percent.
Q. And that would refer, presumably, going back to Appendix 2, to the Calcigex and Inferon?
A. I -- presumably, yes.
Q. Because those were the single-source drugs. Correct?
A. Yes.
Q. And to the extent that Medicare reimbursed for the multiple-source drug here,

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vancomycin, would you expect your staff to take into account the difference between single-source drug prices and multiple-source drug prices in -- in considering changes to Medicare payment policies?
MS. BROOKER: Objection. Form.
A. The only thing I can observe empirically is that I don't recall, in our conversations over the years about changing Medicare drug pricing policy, the distinction between brand and generics arising very often, if at all.
Q. At the time this report was -- was written, am I correct that Medicare was reimbursing at undiscounted AWP for Part B drugs? Correct?
MS. BROOKER: Objection. Form.
A. I -- I believe that's correct.
Q. It was either EAC, according to survey --
A. Right.
Q. -- or AWP. Right?

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A. The only reason I hesitate in response to your question is trying to remember whether dialysis drugs were treated separately from other Part B drugs, but I don't believe they were.
Q. To the extent that -- that dialysis drugs were reimbursed pursuant to 405.517, they were being reimbursed by Medicare at 100 percent of AWP. Correct?
A. That is correct.
Q. And to the extent that the data on the chart at Appendix 2 is -- is accurate, that would indicate that for Calcigex, for example, if it were reimbursed under that methodology, am I correct that every single one of the providers surveyed would be reimbursed at an amount in excess of their acquisition cost? Correct?
A. That is correct.
Q. And for Inferon, all but two of the providers would have been reimbursed at above their acquisition cost. Correct?
MS. BROOKER: Objection. Form.
A. That's what it shows, yes.

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Q. And for vancomycin, at least one provider would have had a cost of $3.45 and a reimbursement amount of $19.17. Correct?
A. That's what the charge shows, yes.
Q. I'm getting a little bit ahead of myself, but did you ever have discussions within HCFA about whether to change that reimbursement methodology for drugs such as this?
MS. BROOKER: I'm going to instruct you to be mindful of not discussing internal pre-decisional deliberations on the record.
A. We proposed, a number of times, to change the methodology, and, in fact, the proposal cited by the President, in his speech that we discussed earlier, was one that we had been advocating for -- within the administration since, I believe, about 1995.
I think it is fair to say as well that I believed, as -- as far back as '95, that 85 percent of average wholesale price as a payment method was inferior to something closer than average acquisition cost, but that the

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administrative difficulties, and the potential administrative burden on physicians as a political issue, if not a real issue, made it likelier that we would be able to succeed with the legislative proposal still tied to AWP than one that went all the way back to its acquisition costs.
Q. Now, as I understand it, from '91 -- strike that.
As I understand it, during the time you were a HCFA administrator, from 1993 until 1997, reimbursement for Part B drugs under Medicare, under the regulation 405.517, was made pursuant to HHS regulation. Correct?
A. That is correct.
Q. And that could have been changed without legislation. Correct?
MS. BROOKER: Objection. Form.
A. Theoretically, yes. We were -- it was my perception, during that period, that the statute -- the statute offered us the alternative of an acquisition price-based methodology, but

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that the Office of Management and Budget, and perhaps the Department of Health and Human Services themselves, would not authorize us to undertake the data collection to determine acquisition costs, and that we -- our perception was we did not believe we had the authority to go to a percentage of AWP as an alternative methodology without legislation.
Q. Well, the -- the regulation that was promulgated in 1991 providing for estimated acquisition cost according to a survey or average wholesale price as published in the Red Book, was promulgated by the Department of Health and Human Services. Correct?
A. That is correct.
Q. And an alternative regulation changing that rule also could have been promulgated by the Department of Health and Human Services any time prior to the enactment of the Balanced Budget Act of 1997. Correct?
MS. BROOKER: Objection. Form.
A. I -- I'd have to check, but it was my

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perception at the time that our legal authority pretty much left us with those -- in the absence of further legislation, pretty much left us with those two alternatives; in other words, 100 percent of AWP or actual acquisition price.
My -- I don't recall whether that was because of a perception that Congress would object to any effort to use a fraction of AWP or -- I don't -- the opinion that we had only those two alternative -- let me restate that.
It was my belief, at the time, that the -- having only those two alternatives was an unavoidable reality. Whether that was legal or political, I'm not sure I was clear at the time, and I'm certainly not clear now.
Q. So, as I understand it, between 1993 and 1997, according to regulation, HCFA could reimburse based upon two methodologies. Correct?
A. That's correct.
Q. One was the published average wholesale price. Correct?

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Correct?
A. That's correct.
Q. Do you have a memory of reviewing this report in 1997?
A. No.
Q. If you look at the page Roman Numeral II of the executive summary, the first sentence of the -- at the top of the page with the first paragraph? Do you see it indicates that Medicare allowed between two and ten times the actual average wholesale prices offered by drug wholesalers and group purchasing organizations for eight of the 22 drugs that were reviewed?
A. That's what it says, yes.
Q. That would be consistent, wouldn't it be, with President Clinton's radio address shortly after the issuance of this report about prices being -- AWP being up to ten times up to acquisition costs. Correct?
MS. BROOKER: Objection to form.
A. I guess it would be.
Q. If you can turn to Page B-3. It's

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Appendix B of the report and the last page of the Appendix B. It's a chart entitled "Summary of wholesale prices and estimated savings for 1996"?
A. I see that, yes.
Q. The very last drug discussed here is J 3370, along the bottom left-hand corner there?
A. Yes. I see that.
Q. And that's HCPCS code. What's a HCPCS code, Dr. Vladeck?
A. It's the system by which HCFA assigned unique billing numbers for most of the services that were billable under Medicare. Unfortunately, there wasn't already a standard industry nomenclature somewhere.
Q. If you turn the page to Page C-2? It's another chart with HCPCS codes in the left-hand column and "drug description" immediately to the right?
A. Yes, sir.
Q. Do you see what at least this OIG report attributes to be the drug associated with Code J 3370?

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A. That's vancomycin.
Q. And that's the same drug as we talked about earlier with respect to the 1992 report on dialysis related drugs?
A. Yes.
Q. And the same drug that's involved, in part at least, in this lawsuit against Abbott?
A. So I understand.
Q. If you turn back to Page B-3.
This chart shows various points, according to OIG, across the top, the fourth of which is the lowest wholesale price found, according to the OIG, for this drug.
Could you tell me, what is the lowest wholesale price found that the OIG reported for vancomycin in 1996 in this report?
A. $3.45.
Q. If you recall, that's the same price that OIG reported as the lowest invoiced price for vancomycin in its 1992 report on dialysis related drugs; wasn't it?
MS. BROOKER: Objection. Form.

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A. I'm sorry. Could you repeat the question?
Q. Sure. You and I looked earlier at a 1992 report on dialysis related drugs?
A. That's correct.
Q. And it showed a number of invoice prices for vancomycin in an array?
A. Right.
Q. And the highest price was just over $26, you'll recall?
A. That's correct.
Q. And the lowest invoice price that OIG found for vancomycin in 1992 was $3.45.
Correct?
MS. BROOKER: Objection to form.
A. That's correct.
Q. And so in 1997 OIG is reporting to HCFA again that the lowest price available for vancomycin, according to their review, was $3.45?
MS. BROOKER: Objection to form.
A. Yes, sir.
Q. If you turn to Nancy-Ann Min DeParle's

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October 1, 1997, response memo, as with the earlier agency response that went out over your name that we reviewed for the -- for the report on generic drugs reimbursable by Medicaid, the first line indicates:

"We reviewed the above-referenced report."

Would you expect staff within HCFA to have reviewed this particular report as indicated in this memo?

A. I'm sorry. I think I need about a five-minute break to regain my concentration.

THE VIDEOGRAPHER: The time is 2:29 p.m. We're going off the record with Tape No. 4.

(Recess taken.)

THE VIDEOGRAPHER: The time is 2:43 p.m. We're going back on the record, continuing with Tape No. 4.

Q. Dr. Vladeck, I'd like to move to a completely different subject. We had talked earlier about whether AWP represented acquisition costs for manufacturers. You were aware, were

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you not, when you were administrator of HCFA, that manufacturers were publishing prices. Right?

MS. BROOKER: Objection. Form.

A. You'll have to elaborate on your question a little bit more.

Q. Sure. We had talked before about published prices that manufacturers would publish to the world as a list price, for example?

A. That's correct.

Q. And you're aware that manufacturers would have, on the one hand, a published price? Correct?

MS. BROOKER: Objection. Form.

A. When you say "on the one hand," that implies there's another hand.

Q. There will be another hand.

A. Yes. Right.

My understanding at the time was that manufacturers would have a published price which would be taken as the average wholesale price.

Q. And but there would be various market

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prices that would be represented by, for example, contract sales with individual customers?

A. That was my understanding, yes.

Q. And that there were various discount structures and rebates and chargebacks that went into whatever the final price would be to a particular customer.

MS. BROOKER: Objection. Form.

MR. AZORSKY: Objection.

A. I don't know that I was sophisticated enough at the time to know about rebates and chargebacks, but certainly in the sense that there were discounts of differential amounts from those published prices I was aware of.

Q. At any time did HCFA communicate with manufacturers about what HCFA expected the published prices to reflect?

MS. BROOKER: Objection. Form.

A. I do not recall any specific instructions of which I was aware. I don't recall any such.

Q. I'd like to contrast that, please, with

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the Medicaid rebate program. Are you familiar with the Medicaid rebate program?

A. In general terms, yes.

Q. Okay. Could you give me your general understanding of what the Medicaid rebate program is?

A. My understanding of the Medicaid rebate program was that in -- manufacturers had the opportunity to enter into agreements with state Medicaid programs in which the state programs would forego from the creation of a formulary or an approved drug list in exchange for which they would provide the program with a rebate relative to the price that Medicaid was paying for the ingredient cost of the drugs.

Q. And so under the Medicaid rebate program if I'm a drug manufacturer and I want my drug to be reimbursed under a particular state's Medicaid program, I would have to enter into an agreement with the state. Correct?

A. That's correct.

Q. And the agreement would provide that I

Videotaped Deposition of THOMAS A. SCULLY, a witness herein, called for examination by counsel for Abbott Laboratories in the above-entitled matter, pursuant to subpoena, the witness being duly sworn by SUSAN L. CIMINELLI, a Notary Public in and for the District of Columbia, taken at the offices of Jones Day, 51 Louisiana Avenue, Northwest, Washington, D.C., at 8:49 a.m. on Tuesday, May 15, 2007, and the proceedings being taken down by Stenotype by SUSAN L. CIMINELLI, CRR, RPR, and transcribed under her direction.

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Q. Pardon me?
A. I'll give you an example of how that works. If you got Calcijex or Zemplar, that's a fairly complicated fighter of vitamin D reimbursement. And what the AWPs were and what the relevant AWPs were in that context when I was at CMS.
So carriers had the discretion, for example, in that case to pay Calcijex and Zemplar the same thing and they were different drugs. They calculate AWP based on different things. So the carriers have a lot of discretion when CMS doesn't give them a national coverage decision what to cover and in many cases what to pay.
Q. At the -- at the bottom of the page of the first page, it says that "on May 1st, 2000, First Data Bank provided these new average wholesale prices to state Medicaid programs." Do you see that?
A. Yes.
Q. And is it your understanding that the, these DOJAWPs were made available to state Medicaid programs?
MR. GOBENA: Object to the form.

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THE WITNESS: I wasn't aware at the time. I've heard of it since.
BY MR. DALY:
Q. Okay. And did -- during your tenure or at any other time, are you aware of CMS directing that the states utilize the DOJAWPs for Medicaid reimbursement?
MR. GOBENA: Object to the form.
THE WITNESS: If they were, I'm not aware of it.
BY MR. DALY:
Q. And during your tenure with CMS, did you have any meetings with any representatives of DOJ or NAMFCU where the DOJ's AWPs were discussed?
MR. GOBENA: Object to the form.
THE WITNESS: Not that I'm aware of. I'm sure -- I'm fairly sure I did not.
BY MR. DALY:
Q. Did not. Okay. Are you aware of the drugs that the United States is suing Abbott for in this litigation?
A. You know, I read the pleading a while

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back, Vancomycin is the only one I remember. I think there's another one.
Q. Have you seen anything suggesting that the drugs are Vancomycin, as you indicated, various forms of sodium chloride, dextrose and water? Is that consistent with your understanding?
A. From what I remember yes. Generally.
Q. And you were aware of the existence of the DOJAWPs while you were CMS administrator?
MR. GOBENA: Object to the form.
THE WITNESS: Yes. I was aware that they had been collected, and suggested to CMS. And at some point later, they would have been sent to the states.
BY MR. DALY:
Q. And if you turn to the attachments, the charts, I guess it would be page 6 of the document. Do you see --
A. The attachments or --
Q. The attachments. The charts. There is like -- there is little numbers up in the upper right-hand corner. I think those are the page

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numbers.
A. On the bottom.
Q. If you go to page 6, you see --
A. I don't see them on mine. Which chart is it?
MR. GOBENA: This exhibit. Wrong exhibit.
THE WITNESS: I'm sorry. I pulled that the wrong one. Too many charts of excessive drug prices. Yes.
BY MR. DALY:
Q. Okay. And in the -- on page 6, you see a variety of Abbott products. Do you see these various dextrose products?
A. These are all Abbott. I wasn't aware of that. But yes, I see it.
Q. And in terms of charts of excessive drug prices that you referred to, these are -- this is a chart that shows what the actual prices for some of those drugs were, correct?
MR. GOBENA: Object to the form.
THE WITNESS: I'm not aware of that. I assume so from the fact that it's a CMS carrier

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directive. That's correct.
BY MR. DALY:
Q. And during your tenure, did you ever, if I asked this forgive me, but did you ever have any discussions with DOJ about the AWPs that they came up with in this document?
MR. GOBENA: I'm going to object and instruct the witness, you can answer the question whether you had them, but I'm going to instruct him not to answer about the substance of any conversations as being covered by the attorney-client privilege.
THE WITNESS: That's easy since I didn't have any.
MR. GOBENA: It took me more words to say my objection than for you to answer.
THE WITNESS: That's our goal for the rest of the day.
BY MR. DALY:
Q. And do you have any information as to why the United States and the Department of Justice waited six years after putting forth the true AWPs on

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this chart that the DOJ waited six years to unseal the case against Abbott?
MR. GOBENA: Object to the form. Instruct the witness not to answer to the extent the answer goes into attorney-client communications.
THE WITNESS: I was unaware that it was the case until I was called about the deposition.
BY MR. DALY:
Q. Now, on page 2 of the document, CMS directed the carriers to consider some of the drugs in setting reimbursement levels, but then with respect to the drugs in attachment 2, the carriers were directed that "you are not to consider at this time using the DOJ data for these drugs." Do you see that? The top paragraph?
A. Yes. Yes.
Q. And attachment 2 are 14 chemotherapy drugs in three clotting factors. And my question is, do you know why CMS directed that the carriers should not consider the DOJAWPs for those drugs?
MR. GOBENA: Object to the form.
THE WITNESS: I do not -- I don't know

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why. I'm presuming that it was politics. I'm trying to avoid the ones that created the greatest political sensitivities which were the cancer drugs.
BY MR. DALY:
Q. Down further on page 2, the second to last paragraph, there was a direction to the carriers that essentially said that -- and you're welcome to read it, either before or after I summarize it -- but essentially says that if you get complaints from providers about -- that these DOJAWPs are too low and that the provider X can't get the drug for that price, that they should either call one of the wholesalers at the 800 number provided or call one of the manufacturers. Do you see that language there?
A. Uh-huh. Yes.
Q. And would that have been a way to solve the provider access problem?
MR. GOBENA: Object to the form.
THE WITNESS: Could have been a haphazard way if you're giving the carriers discretion to figure out to pay a reasonable price in their judgment, which happens in many cases based on local

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pricing, and make sure that providers can access the drugs in a reasonable margin, I think it probably would be one way to do it. But it's certainly not an efficient way to do it.
There are other examples where I try to figure out what the right price to charge is not an easy process. So I mean, when I approved drug eluting stents a few years back, I had my physicians call around Europe to find out what companies were charging there. Which was not a particular popular way to do it, but it's the only place in the world they were being sold, so it's not an easy -- if it was easy to figure out the right price to pay, you wouldn't be here.
BY MR. DALY:
Q. One of the problems that you had raised in some of your testimony that we'll get to is that you know if you simply reduce AWP to -- or I'm sorry, if you reduce the reimbursement to, you know, 85 percent or 80 or 75 percent of AWP or 50 percent of AWP, if that's what the data is showing is the actual acquisition costs on average, the problem with doing

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actually came out a couple days before you testified on September 21st, is that your recollection?
A. In the Finance Committee.
Q. Pardon me?
A. In the Senate Finance Committee, that's right. I'd have to look, but yes. After this, the other testimony was in May.
Q. And if you'll turn to the second to last page of this exhibit, you'll see a memorandum from you to Laura Dummit. Do you see that?
A. Yes.
Q. And this is a memorandum indicating that you received and had reviewed the report?
A. Yes.
Q. And in the narrative of your email -- or I'm sorry, not email, but your memorandum to Laura Dummit, you indicate that "the GAO confirms the findings of its previous reports along with the previous reports from the Office of the Inspector General that Medicare payments for drugs are substantially higher than the actual cost to physicians and other providers acquiring these

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drugs." Do you see that language?
A. Yes.
Q. And that's a reference to some of the other reports that we have looked at and discussed today, correct?
A. Yes.
Q. And so flipping back to the report itself then, do you recall generally the findings of the GAO, that coincided with your testimony?
A. Generally.
Q. Tell me.
A. I mean, I haven't read it in many years, but I'm sure that they found it.
Q. It's summarized actually under results in brief on page 4 of the document.
A. Yes.
Q. And in the first paragraph, about six or seven lines down, it says, "for most physician administered drugs, the average discount from AWP ranged from 13 to 34 percent, two physician administered drugs had discounts of 65 and 86 percent," do you see that?

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A. Yes.
Q. And that was consistent with earlier reports that you had seen, correct?
MR. GOBENA: Object to the form.
THE WITNESS: Yes.
BY MR. DALY:
Q. And then on page 9, if you'll turn to that.
A. Okay.
Q. And this section is halfway down the page, it's -- the caption is Medicare payments for drugs are based on published AWPs. Do you see that?
A. Yes.
Q. And in the text, it says, "Medicare bases its reimbursement to physicians and other providers of drugs on AWP which is often described as a list price, sticker price, or suggested retail price reflecting the fact that AWP is not necessarily the price paid by a purchaser or a consistently low or wholesale price." Do you see that language?
A. Yes.
Q. And you agree with that, do you not?

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A. Yes.
Q. If you turn to page 19 of the document, Mr. Scully, I just wanted to ask a question. In the middle of the -- or towards the end of the first full paragraph, see the language that says, "we did not analyze the costs of infusion therapy drugs provided in the home setting because they do not account for a substantial share of Medicare drug spending or volume." Do you see that?
A. Yes.
Q. And what are infusion therapy drugs?
A. In the home setting.
Q. In the home setting. Yes.
MR. GOBENA: Object to the form.
THE WITNESS: Infusion therapy drugs, I'm not sure what the most common ones are in the home setting. But probably a small piece of the drugs. I mean, in the home health setting, there are some patients that go home and still have Lincare or somebody deliver home health infusion drugs.
Vancomycin might be one of the higher ones, I would think. Sometimes people go home from

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the hospital and have antibiotics. So that might be an example of that, but that's probably a much smaller volume than nutritional outpatient drugs. Maybe not for Vancomycin, but it would be for most drugs. Certainly Procrit and some of the other higher -- Remicade are generally done in a physician's office or hospital outpatient departments.

BY MR. DALY:

Q. And do you agree with the statement of the GAO here that these drugs do not account for a substantial share of Medicaid drug spending or volume?

MR. GOBENA: Object to the form.

THE WITNESS: I don't know about volume, but the biggest chunk of the -- by pure proportion is oncology drugs, which is why the focus was oncology and to a lesser degree rheumatology. In a reform effort, but I'm not sure about volume and certainly pure dollars spent, oncology is the dominant factor.

BY MR. DALY:

Q. On page 28 of the document, sir, GAO

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states at the very top that "in conducting this study, we interviewed officials at CMS, VA, HHS, OIG and DOJ." Do you see that?

A. Yes.

Q. Did they meet with you at all?

A. I don't remember that they did, and my guess is that I probably wasn't in office confirmed by the time they actually finished doing the research on this. If they put it out in September and I came in May. But I don't remember meeting with them.

Q. And back to the business of the home -- the home infusion drugs, I mean what -- I just want to understand how that part of the business operates. Home infusion is for folks who are able to be treated at home for whatever it is that they are suffering from?

A. Yes.

Q. And there are home infusion companies, for example?

A. Yes. The two biggest are probably Lincare and Aprea.

Q. And what's the second one?

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A. Lincare and Aprea I would say are probably the two biggest companies. They do home delivery of oxygen and respiratory supplies and home infusion. So yes, if you're capable of going home and you need some medications at home, they will deliver the therapies at home.

Q. And the home infusion business serves an important purpose within the health care world because it keeps people out of hospitals, correct?

MR. GOBENA: Object to the form.

THE WITNESS: Spend a couple of hours on that. Yes, in theory, when it's run right, there is a massive home health reform going on right during this time, because home health itself had had some pretty significant reimbursement issues. And probably the biggest set of provider enforcements of the '90s were home health providers. So there was certainly a lot of inappropriate behavior going on in home health certainly in the early '90s.

BY MR. DALY:

Q. But in theory, I think you said one of the advantages of being able to provide care for people

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in their homes is that they don't have to have the burden of being in the hospital and the costs associated with hospitalization, correct?

A. In theory.

MR. GOBENA: Object to the form.

BY MR. DALY:

Q. In theory, yes?

A. In theory, that's probably correct, yes. And that the patients prefer it.

MR. GOBENA: Same objection.

(Exhibit Abbott 187 was marked for identification.)

BY MR. DALY:

Q. Mr. Scully, I've handed you what we've marked as Exhibit Abbott 187, which is a copy of your live testimony before the Committee on Energy and Commerce September 21, 2001. Is that what you recognize it to be?

A. Yes.

Q. If you turn to page 83 -- I mean, this document starts on 82, but page 83 of this particular record, it's the second page of the document. Do you

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Q. I'm not complaining or criticizing what you did.
A. When I started trying to fix this, the vast bulk of people told me I was on a suicide mission and that it was crazy. And I did get it fixed, and it was largely because we operated in the political milieu that we had.
Q. And my question was simply that you had access to AMP information, right?
A. Yes.
Q. And in fact, CMS had had access to AMP information ever since the Medicaid rebate program went into effect in 1991 or 1992, right?
MR. GOBENA: Objection to form.
BY MR. DALY:
Q. True?
MR. GOBENA: Objection to form.
THE WITNESS: Yes. In the format it was coming in which was somewhat flawed.
BY MR. DALY:
Q. And your view was that while not perfect, AMP information approximated ASP, correct?

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A. The concept was similar.
Q. Okay. And my only question was whether you or any of your predecessors at CMS ever went to the manufacturers and said, hey, I got your AMP, we know that your AWP is substantially higher or vastly higher, or as you put in your testimony, pretty much air. And we all know that, and what we'd like you to do is to report a lower AWP. Did you or any of your predecessors ever do that?
MR. BREEN: Objection to form.
MR. GOBENA: Objection, form.
BY MR. DALY:
Q. Go ahead.
A. I think the record shows that both the Clinton Administration tried through various mechanisms to do surveys, get reports, get the carriers to lower their prices. And they consistently got, I believe from an undereducated Congress, a lot of push back. And they consistently dropped those efforts. Including a moratorium for one year from Congress on doing anything.
Q. So the answer to my question, to your

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knowledge, the manufacturers were never asked to report something lower than AWP that would be used for reimbursement?
MR. GOBENA: Objection to form.
BY MR. DALY:
Q. Correct? During the 1990s and into at least through the end of your administration?
MR. GOBENA: Same objection. Asked and answered.
THE WITNESS: I'm not aware of any efforts specifically like that outside of surveys.
BY MR. DALY:
Q. Let's turn to -- what exhibit are we on now? Exhibit Abbott 191. Turn to page 14.
A. Okay.
Q. And 14 is, I believe, a letter or some other submission that you made to the committee, is that correct?
A. I assume. I haven't seen this before.
Q. Well, if you take a look at pages 14 and 15, there is -- it's dear Chairman Johnson, and then it's signed on page -- not signed, but indicates that

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it's from you on page 15. Do you see that?
A. Yes.
Q. And you know you can take a moment to look at it, but is this a written submission that you made to Chairman Johnson?
A. It certainly looks like it.
Q. And on the page 14, and you talk under the heading form of administration, you say, "22 of the 35 drugs, accounting for 38 percent of carrier spending are administered by intravenous infusion." Do you see that?
A. Yes.
Q. And this would include all of the drugs that are administered through intravenous infusion correct?
MR. GOBENA: Object to the form.
BY MR. DALY:
Q. All of the drugs covered by Medicare Part B. Go ahead.
A. That's what -- yes. Intravenous infusion. Part B only covers drugs that are not usually self-injected, is the definition.

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Q. And we had looked at this earlier, in the context of the GAO report that came out in September of '01, there was that indication on page 19 that the GAO had not researched the infusion drugs because they were a small part of the Medicare Part B pie. Do you recall that?
MR. GOBENA: Objection.
THE WITNESS: Home infusion.
BY MR. DALY:
Q. Home infusion. And when you talk about intravenous infusion here, that would include the home infusion drugs as well, wouldn't it?
A. I don't know, to be perfectly honest with you. The bulk of the drugs and the bulk of the spending is physician office and outpatient infusion. So home health infusion, which is usually the same drugs, may or may not be. I'm not sure.
Q. And are you aware of whether or not for home infusion that Medicare provides any kind of service fee for the administration of home infusion drugs?
MR. BREEN: Objection. Form.

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THE VIDEOGRAPHER: I'm sorry. Who made that objection?
MR. BREEN: Breen.
MR. GOBENA: You can answer.
THE WITNESS: Prior to --
MR. DALY: If they just object on form, just go right ahead.
THE WITNESS: Prior to the CMS change after they went did the AWP reform, I don't believe there was any service fee for home infusion or home inhalation delivery. And I believe there is now. But there was no service fee at the time.
BY MR. DALY:
Q. And I'm just looking at your answer here on the screen. Prior to CMS change, after they went to the AWP form -- I'm not sure if I'm understanding. Can you just expand on that a little bit?
A. After we changed the AWP to ASP plus 6 in the 2003 bill, there was very little to zero discussion and/or thought about any of the home health drugs. It was generally not a discussion of the vast bulk of the spending was in oncology and

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rheumatology and other physician office drugs.
Q. So does that mean you don't --
A. So after I left, and after the bill went into effect, the home health providers came in and raised quite a ruckus about the lack of dispensing fee mainly for inhalation drugs, but also I believe for home health infusion. And CMS did in fact basically create a home -- at least for respiratory drugs, and I assume it was for infusion as well, a dispensing fee for those drugs, which again similar to oncology, was a small -- the increase they created for dispensing the drugs was a small piece of the AWP drug savings in that arena, I believe.
Q. So it's your understanding that prior to the MMA, there was no separate service fee for home infusion?
A. I may be wrong, but I don't think there was.
Q. Okay. And when the MMA was instituted, you know, as a result of your efforts, there was no provision in that act for a service fee for home infusion either, is that what you're saying?

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A. I'm pretty sure there was not.
Q. And that subsequent to the institution of the MMA, that's when the home health providers came forward and something was done to rectify that?
A. And it was done on --
MR. GOBENA: Objection to form. Sorry. Go ahead.
THE WITNESS: I know it was done for respiratory drugs. I believe it was for infused drugs as well. I'm not sure, but I'm pretty -- I know respiratory drugs it was. And I was actually -- it was just something that was not considered in 2003. And CMS, I think, decided that was an inadvertent error and they put in a dispensing fee for infusion drugs -- I mean, for respiratory drugs. I'm not sure -- I'm fairly certain it covered infusion as well.
BY MR. DALY:
Q. And prior to something being done about that after the MMA was put into effect, is it your understanding that the home infusion care providers were relying on the spread between their acquisition

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costs and AWP to fund the services that they were providing?
MR. GOBENA: Objection. Form.
THE WITNESS: I assume that that was part of how they paid for the cost of delivering the services. Yes.
(Exhibit Abbott 192 was marked for identification.)
BY MR. DALY:
Q. Mr. Scully, I've handed you what we've marked as Exhibit Abbott 192, bearing Bates stamp numbers HHC 0030446 through 0449, which is a letter from the -- excuse me, Long-Term Care Pharmacy Alliance to you. And do you recognize this letter?
A. No.
Q. In the first paragraph, it says, "I am writing," this is a letter dated July 22, 2002. And it is, it says in the first sentence, "I am writing to thank you for taking the time to meet with us on June 27." Do you see that?
A. Yes.
Q. Do you have any recollection of meeting

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with representatives of the LTCPA in June of -- or the summer of 19 -- or of 2002?
A. No.
Q. No. You meet with a lot of people, though?
A. I met with a lot of people.
Q. Have you ever heard of the LTCPA?
A. Vaguely.
Q. Okay. And you understand them to be some sort of trade association for home infusion?
A. I thought it was a trade association for nursing home pharmacists, so there may be home infusion people in it, but I think it's nursing home pharmacists. Maybe I'm wrong about that, but I think that's what it is. The trade association for most of the home infusion people is AA Home Care, I think, a different group.
Q. The bottom of the first page, they say in their letter to you, "right now, most of the reimbursement for the special services provided by long-term care pharmacies is implicit. That is to say, we find our reimbursement in the spread between

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the prices at which we purchase a drug and the average wholesale price of the drug." Do you see that language?
A. Yes.
Q. And do you have an understanding that that is a correct statement?
MR. GOBENA: Objection to form.
THE WITNESS: Yes. I mean, I think the issue is a matter of proportion. It's similar to the oncologists, which is they clearly made money on the spread and how much of that -- what measurement appropriately should have been paid to deliver the service, some portion of it. I don't know enough about the nursing home issue here to know how much there was. This is a small -- you know, nursing homes are similar to home infusion, where they have Part B Medicare patients in the home, and they provide the service and they get paid for it.
So how much did they make on AWP spread and how much of that would have measurably been put back in if they had a more rational policy into a servicing fee? I'm not sure, but my guess is much

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like oncology, it probably wouldn't be all of it. And I don't have all the facts to tell you that. I mean, I did know on the dialysis side, it probably was appropriate to put all of it back in. In many other settings, it was not.
BY MR. DALY:
Q. I'm going to hand you what's been previously marked as Exhibit Abbott 018, which is testimony that was submitted at the hearing that we've been talking about on October 3, 2002 that you attended by the National Alliance for Infusion Therapy and the National Home Infusion Association. And do you recall the presentation that these entities made at the hearing on 10-3-02?
A. No. I'm sure I wasn't there.
Q. Well, you were there for your part. This is the same hearing you were at.
A. I traditionally left as soon as I was done.
Q. As soon as possible.
A. As did every other administrator.
Q. Now, did you ever have any meetings or

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correspondence with either of these entities concerning their concerns relating to proposed amendments to the Medicare reimbursement structure?
A. Not that I remember. They were not major players.
Q. And if you drop down to the, on the first page under Medicare coverage and payment for home infusion drug therapy, do you see that?
A. Yes.
Q. In the first sentence, they say, "providers and suppliers of infusion drug therapies in the home setting are not paid separately by Medicare for the critical services and practice expenses described above." Do you see that?
A. Yes.
Q. And that's, I take it, having discussed it with you earlier, that's consistent with your understanding, that they were not receiving a separate reimbursement for services on the home infusion front, is that correct?
MR. GOBENA: Objection to form.
THE WITNESS: I don't believe -- I do not

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believe they were getting a separate payment for services. Yes.
BY MR. DALY:
Q. And as they say here, continuing in that paragraph, the only items that we -- "the only items that are explicitly covered and reimbursed under this limited benefit are the drugs, equipment and supplies," do you see that?
A. Yes.
Q. And that, based on your recollection of the circumstances, appears to be a correct statement, right?
MR. GOBENA: Objection to form.
THE WITNESS: Yes. And I would say while I'm not qualified to do it here and obviously we completely ignored these guys in the legislation, there was a thorough discussion on the oncology side that the AWP margins were far more than needed on the practice expense add back by whatever I said, 1 to 20 or 1 to 5. On dialysis, it was 1 to 1. And for these guys, it was never discussed.
So what's the appropriate -- what were

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their AWP margins, and how big were they, and were they appropriate or not, and what should have been added back as far as I know, it never came up.
BY MR. DALY:
Q. So the -- as you said, these -- this group was this group being the home infusion caregivers, they were ignored in the legislation you were working on, correct?
MR. GOBENA: Objection. Asked and answered.
THE WITNESS: On AWP, I would say that is correct. They had other -- some of the members and manufacturers had other issues. And the noise from the oncologists was very loud. And obviously this is part of the Medicare drug benefit, which is a very big, very controversial bill. And I don't think any of us really thought about these guys, to be perfectly honest, until after the bill passed.
BY MR. DALY:
Q. Now --
A. In four months in the Medicare conference committee, and I don't think I missed any of it, or

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whatever you want to call it, the quasi conferences, it was, you know, Senator Baucus and Senator Roe and Republican members on both sides. I don't remember this ever coming up.
Q. And what you said earlier is that you believe that with respect to home infusion, that the situation was addressed after the MMA was put into place and after you had left the administration, correct?
MR. GOBENA: Objection to form.
THE WITNESS: I should know this, but there was -- I don't know on home infusion. I assume it was. I know on respiratory therapy drugs, there was a dispensing fee created administratively by CMS the following year on the argument, for the respiratory drugs, that there was no margin left, and the service wouldn't be provided.
So CMS created a dispensing fee, which I believe was 55 bucks or something for the first 60 days, and then it went down from there. I think it's now down to 28, it was phased down. But for respiratory therapy, there was a dispensing fee

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created by CMS in 2004 by regulation, to deal with this. I assume it was done for infusion as well, but I don't know, to be honest with you.

BY MR. DALY:

Q. As part of the MMA, were some drugs kept at 95 percent of AWP? When I say kept at, was reimbursement kept at 95 percent of AWP?

A. I think I may be wrong, but I think maybe some IVIG. Something was. I can't remember what.

Q. And what would that stand for?

A. Intravenous immune suppressant, I forget what the G is, but it's a -- it's a fairly widely used immune deficiency set of -- I guess they are theoretically drugs or biological therapies. I think that's the only one, IVIG. I may be wrong. You may be aware of it. I'm not sure. There were a couple of carveouts. I can't remember exactly what.

(Exhibit Abbott 193 was marked for identification.)

BY MR. DALY:

Q. And the court reporter is handing --

A. Which reminds me my law firm does work for

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CLB, which is an IVIG company. Just remembered when I answered your question. They have a very narrowly tailored series of drugs.

Q. I've handed you what the court reporter has marked Exhibit Abbott 193, and it's a CMS manual system document that's entitled some sort of change request. And without going into the details of this particular document, Mr. Scully, what is, what is this CMS manual system?

A. What is the manual system? It's a subregulatory director -- directive to carriers and fiscal intermediaries and CMS contractors just how to carry out.

Q. So this is going out to carriers telling them what to do?

A. It's generally available to providers as well depending on their area.

Q. And if you'll turn to -- well, turn to the second page of the document, it's talking about the MMA, and appears to be talking about certain drugs that are going to be kept at 95 percent of AWP for reimbursement purposes.

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And if you flip over to subparagraph five on the third page of the document, it states that "payment limits for infusion drugs furnished through a covered item of durable medical equipment on or after January 1, 2004 are 95 percent of the AWP reflected in the published compendia as of October 1, 2003, regardless of whether or not the durable medical equipment is implanted." Do you see that language?

A. Yes.

Q. And do you recall working on a carveout from the ASP plus 6 or the 85 percent of AWP that was part of the MMA in January of 2004?

A. I was gone.

Q. Well, this, this -- well, I'm asking you, did you work on this?

A. 2004. I was gone.

Q. This is like a few weeks after you left.

A. Yes. No. I don't. I pretty much -- the bill passed and I was -- you know, the bill passed in December and I was pretty -- declared to be heading for the exits. I had basically stayed to get the

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bill passed probably six months longer than I originally planned. So no, I don't remember this. It does appear if there was a carveout -- so what you're saying is for DME drugs, infused home drugs, there was a carveout for 95 percent of the bill.

Q. That's what I'm asking. That's what it looks like to me. I'm asking you.

A. I don't remember that. But it appears that there was in the statute, but I just don't recall. It may have been, we had many issues in the bill.

Q. So this carveout was not something that you would have discussed with staff in December or November or October of 2003?

A. I don't remember. It was in the legislation? It must have been if it's in here. There was a carveout of the legislation for home infused drugs?

Q. That's what it suggests. Yes.

A. Well, I just don't have the legislation in front of me, but I'm sure if that was, it was done for a reason. And I'm -- I just don't remember if

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there was a carveout. If it was, they probably carved it out for the reasons I discussed because there was no dispensing fee.
Q. Because of what?
A. I'm assuming if there is a carveout for home infusion drugs, it was done largely for that reason.
Q. Because there was no dispensing fee is that what you said?
A. But I was not aware of that until you showed it to me. If I was -- I may have been aware at the time, but I had forgotten. It's not something that I discussed widely with the staff at the time.
MR. GOBENA: I'm going to object to this line of questioning, to the extent you're saying there was a carveout beyond December 31st, 2004. If you look at the second page, it covers the time period for which this memorandum is operative.
BY MR. DALY:
Q. When did you leave?
A. January 4th was my last day, 2004.
Q. That's when you left CMS. Correct?

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A. Yes. I believe that's the right final day.
Q. And if you look at the, if you look at the attachments, there is the addendum F, which is the list of drugs, are you saying you have no recollection of this during your tenure with CMS?
A. It's vaguely coming back to me that we did some carveouts for blood -- for clotting factors. I wasn't aware we did it for home infusion drugs. If there is a home infusion carveout in the bill, I have just forgotten it. There may have been. I knew we did one for clotting factors, and just looking at this rule, it was largely Senator Grassley's staff that was doing this. So I should be aware of it, but I just -- was it a one-year provision or a permanent one? I just don't remember.
Q. Well, I mean, I think this thing changed over time, but certainly this is talking about it being in effect for -- effective January 1, 2004 according to the addendum.
A. Yes.
MR. GOBENA: Through December 31, 2004.

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BY MR. DALY:
Q. Well, at least for a year.
A. I think there was a one-year transition for a few things. I just don't remember which -- clotting factor, I know, was one. If we did it for home infusion drugs, I forgot.
Q. And it would appear based on Exhibit Abbott 193 that it was also at least a one-year carveout for infusion drugs that are delivered through DME, correct?
MR. GOBENA: Object to the form.
THE WITNESS: If I remember for that entire one year, we also had 85 percent of AWP. We didn't get ASP plus 6 until a year later either.
BY MR. DALY:
Q. Right.
A. Right? So there was a one-year modest cut from AWP and then a transition to ASP plus 6, right?
Q. I believe that was the sequence. And so for this first year, according to this, these drugs issued in a home care setting through a DME, durable medical equipment, would stay at 95 percent of AWP

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for the reimbursement, correct?
A. As the clotting factor and the rest went to 85? You remember -- I had forgotten, but I guess that's right.
Q. Okay. And that would be with knowledge that the ASP for these drugs was much lower than 95 percent of AWP, correct?
MR. GOBENA: Object to the form.
THE WITNESS: Obviously, I don't have a great recollection of this particular issue and how it was treated legislatively. It was not -- it was not one of the top 200 issues I was dealing with.
BY MR. DALY:
Q. But you knew, for example, that -- you know, I think you use it in your -- as an example in some of your testimony, that the AWP for Vancomycin, for example, was higher than the ASP for Vancomycin, correct?
A. Yes.
Q. And so if this exception was going to treat Vancomycin and allow it to be reimbursed at 95 percent, it would -- of AWP, it would be, that would

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be a level that was much higher than the ASP for Vancomycin, correct?
MR. GOBENA: Objection. Form. Also going to object to the previous question. I didn't get a chance to get in there. Object to the form on that. You can answer the question.
THE WITNESS: Yes. My guess would be obviously it was a transition for one year to 85 percent of AWP for all drugs, 95 percent for clotting factor and some other drugs. And I'm sure they didn't go through drug by drug and look at the margins. I assume there were other home health infusion drugs, for which they felt the margins for that one year may have been sensitively narrow, and so they kept it at 95 percent.
I'm just guessing -- just remember, my testimony for Vancomycin, the spread was pretty big and there probably wasn't a whole lot of worry about 85 percent not being big enough to cover it, so it's probably not the reason that drove the policy.
(Exhibit Abbott 194 was marked for identification.)

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BY MR. DALY:
Q. And Mr. Scully, I've handed you what the court reporter has marked as Exhibit Abbott 194, which is a copy of at least portions of the MMA itself. And I would ask you to turn to page 23 of that document. And you had asked whether this was a carveout in the legislation itself, and I just want to direct you to page 23 at the bottom, subparagraphs D-1 and 2.
A. Okay.
Q. And does that appear to be the legislative carveout for the rule that we were just looking at?
A. Refreshing my memory, I had forgotten we did that. Yes.
MR. GOBENA: While Mr. Daly is getting his exhibit out, I'll note the first page, it says that this piece of legislation was effective December 8, 2003 to December 31, 2004.
MR. DALY: Anything else you want to point out?
THE WITNESS: Yes. This was a one-year transition. It went to ASP plus 6 in 2004, is that

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right?
BY MR. DALY:
Q. I believe that's right.
(Exhibit Abbott 195 was marked for identification.)
THE WITNESS: Good heavy one. I can take care of the rest of those if you like.
BY MR. DALY:
Q. And you mentioned that, you know, this might have been a one-year carveout. And Mr. Gobena seems anxious to point that out. Taking a look at Exhibit Abbott 195, which I've handed you, this is certain amendments that went into effect with respect to the MMA effective December 20, 2006. Do you see, do you see that?
A. Yes.
Q. And if you would turn to page 21 of this document, and subparagraphs D-1 and D-2. Do you see that the carveout that we identified that was in effect for 2004 remains in effect today?
MR. GOBENA: Object to the form. Excuse me.

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THE WITNESS: Yes. I wasn't aware of that, so there is still -- they're still 95 percent of AWP today?
BY MR. DALY:
Q. That's what the statute says, isn't it?
A. Yes. I wasn't aware of that. That's what the statute says.
MR. BREEN: Just for clarification, Mr. Daly, are you referring to subparagraph D little I, which ends with 95 percent of the average wholesale price for such drug in effect on October 1, 2003?
MR. DALY: And D-2.
MR. BREEN: Say again?
MR. DALY: And the next paragraph, D Romanette i and D Romanette ii.
THE WITNESS: Until they froze it at the date of passage, October -- they picked the -- 95 percent of the AWP in place in October 2003, and froze it. I had forgotten that.
BY MR. DALY:
Q. And so at least for the drugs that are

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subject to this carveout in the home infusion setting, Congress has kept the reimbursement of those drugs at 95 percent of AWP as of --
A. As of October 2003.
Q. That's correct, isn't it?
A. I guess it is. That's what the statute says. Another piece of sausage. I have just forgotten that we did that, to be honest with you, which I assume is why they don't have a dispensing fee for anything but respiratory drugs, because they didn't do that for respiratory drugs.
Q. So it would appear that Congress, at least for these drugs and in that setting of home infusion, has determined to continue to subsidize the provision of the services by overpaying for the drugs, correct?
MR. GOBENA: Object to the form. The legislation speaks for itself.
MR. BREEN: Objection to the form.
BY MR. DALY:
Q. You can go ahead.
A. Yes. I was surprised to see this. I forgot we did it. It was certainly never discussed

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by members. I'm sure the staff -- staff person who wrote it works with me at Alston & Bird, so I'll go back and ask him, but I'm sure that it's probably, they froze it to freeze it, and some level of cross-subsidy apparently. I'm not sure what the congressional intent there was, but I think it was Senator Grassley's staff that did that provision. So I had totally forgotten we did it. That it was in the bill. It wasn't something that was widely discussed at all.
Q. And are you aware of whether the drugs that DOJ is suing Abbott for, many of those drugs are used in the home infusion context and using DME?
MR. GOBENA: Objection to form.
THE WITNESS: As of today, I'm aware of it. I wasn't aware of it before.
BY MR. DALY:
Q. But as of today, you are?
A. Yes. Obviously looking at the drug list.
Q. Page 27 of Exhibit Abbott 191, which is your 10-3 -- yes, your October 3 -- excuse me, October 3, 2002 testimony. I just want to direct you

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to page 27.
A. 27?
Q. Yes.
A. Okay.
Q. And in your testimony in response to Mr. English, you indicate that you think -- well, you state, "I think there are a lot of different provider areas that may have small impacts from AWP, and we are certainly willing to work with the committee to identify those." And then you mentioned oncology as -- oncology and dialysis and hematology being sort of the big three, right?
A. Yes.
Q. And then you say, "I think almost every physician to some degree that administers drugs probably has some beneficial cost shifting benefit from AWP, I think those are the three big areas," you see that language?
A. Yes.
Q. And that was a true statement, correct?
A. Yes.
Q. On page 31, I just want to get a fix for

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-- and we may have covered this in some part in the sort of background section that we did at the beginning, but you state at the bottom of the page, "I had been working on Medicare for over 20 years and there has never been any law passed more complicated than this one." How far back does your work on Medicare go?
A. In a minor way, probably 1982. But in a full time way, 1989.
Q. And what were you doing with respect to Medicare in 1982?
A. Not much. Occasional staff work for Senator Gorton, but very, you know, minor.
Q. And '89 would have started your work with the Bush Administration?
A. And OMB. Yes.
Q. And if you would turn to page 34. If you -- actually, if you look at 33, the page before, it looks like you finished up your testimony, and then George Reeb, R-E-E-B, got in the hot seat. And began to talk a little bit about Medicare and Medicaid. And on page 34 of Mr. Reeb's testimony, he states

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that "this occurs largely because Medicare and Medicaid base reimbursement to physicians and suppliers on inflated average wholesale prices." Do you see that language?
A. Where is that? I'm sorry.
Q. I'm sorry?
A. Where is it, second --
Q. I think it's the second full sentence on page 34.
A. Oh, yes. Okay.
Q. Do you see that language?
A. Yep. I'm getting tired so --
Q. And in the -- I know the feeling. And in the Medicaid world, as we talked briefly earlier, Medicaid state agencies are reimbursed typically on some formula of AWP minus a certain percent or sometimes, for example, WAC plus a certain percent, is that your general understanding?
MR. GOBENA: Objection to the form.
THE WITNESS: Yes. It is.
BY MR. DALY:
Q. And here, in the -- in this next

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paragraph, there is discussion of Medicare reimbursing physicians at 95 percent of AWP. That was the law prior to the institution of the MMA, correct?
MR. GOBENA: Object to the form.
THE WITNESS: Yes.
BY MR. DALY:
Q. Okay. And in the next sentence, it says, "similarly, state Medicaid agencies reimburse pharmacies at AWP minus an average of 10.3 percent." Do you see that?
A. Yes.
Q. And is that consistent with your understanding of the discounts that states were typically reimbursing their pharmacy purchases at?
MR. GOBENA: Object to the form.
THE WITNESS: I don't recall. I'm guessing GAO must be -- or the IG must be close to correct. That's probably a wide average.
BY MR. DALY:
Q. Couple paragraphs down, maybe three paragraphs down the statement, it says, "although

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this hearing pertains to Medicare, I would also like to mention our work on Medicaid primarily because it confirms that AWP is not a realistic basis for drug reimbursement." Do you see that language?
A. Yes.
Q. And do you agree with that statement, in the Medicaid context?
A. Yes. For the most part. I would add the state situation is much more complex, because of rebates which doesn't happen in Medicare. The states get rebates on Medicaid and so the price they actually pay is complicated by the rebates they get back.
Q. In the next sentence, it states, "in Medicaid, we found that there was a significant difference between the pharmacy acquisition costs for drugs and their published AWPs. In our latest report we found that pharmacy acquisition costs ranged from 17 to 72 percent below published AWPs." Do you see that?
A. Yes.
Q. And was that a caution of concern for you?

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MR. GOBENA: Object to the form.
THE WITNESS: Yes. As I said, as I explained earlier today, you know, we could help share information with the states, but Medicaid is a state managed program. And the states had the right to negotiate whatever price they thought was appropriate.
BY MR. DALY:
Q. Within reason, right?
A. Within reason.
Q. And did you think discounts of 72 percent below published AWPs were within reason?
MR. GOBENA: Object to the form.
THE WITNESS: I think we pushed the states to negotiate more aggressively the lower prices and gave them as much information as we could. And we also -- you know, they obviously had rebates that were impacted below this. So yeah, but I mean, the reality is it was my direct responsibility to fix Medicare. It was not my direct responsibility to fix 56 different Medicaid programs.
BY MR. DALY:

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Q. And to do so -- well, I mean, I take it that fixing 50 state Medicaid programs would be, you know, versions of trying to fix Medicare times 50. Is that fair?
A. Yes.
Q. Because each state would have its own political issues, for example, correct?
MR. GOBENA: Object to the form.
THE WITNESS: Yes. Medicaid is 54 territories, 55 different programs that are all complex and all different payment rates and different politics and makes Medicare reform look simple.
BY MR. DALY:
Q. And for example, you would have, you know, providers within each state, this time including pharmacies, for example, that would be complaining to state governments if reimbursement levels attempted to be reduced, be reduced, is that true?
MR. GOBENA: Objection. Form.
THE WITNESS: Yes. Every state had different pharmacy politics with the providers and what the dispensing fees were and what the

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acquisition costs were. Yes.
BY MR. DALY:
Q. But it was your view, it was CMS's view that if a state wanted to pay to reimburse pharmacies at AWP minus, say, 10 percent, for example, even though the actual acquisition cost of the drug might be AWP minus 72 percent, you did not find that to be unreasonable?
MR. GOBENA: Objection to the form. This witness is not here as a 30(b)(6) testifying about CMS's views.
BY MR. DALY:
Q. Go ahead.
MR. GOBENA: You can answer.
THE WITNESS: My personal view was that it was -- was it unreasonable? Yes. I mean, I spent a lot of time complaining to states about trying to make sure that they paid the lower cost for drugs, and some did. And I pushed on a lot of states to hire third party PBMs which a lot of them did, to buy their drugs and lower their acquisition costs and come up with a market-based pricing, which

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increasingly some did.
And I authorized the number multi-state purchasing groups which were controversial for states to go ahead and use private PBMs to lower their cost. So it was a concern. For me it was more direct and immediate concern for the Medicare program, which I was directly responsible for. But when states asked me what to do on Medicaid drug pricing, my general advice, which a lot of them did, was to hire a PBM to go out, put them at risk, and drive prices down, which a number of them did.
BY MR. DALY:
Q. In your testimony in 2003, you testified that Medicaid has actually become a larger program than Medicare. Do you recall that testimony?
A. Yes.
Q. And so why do you say that you didn't have direct responsibility for trying to reduce the federal government's Medicaid payments?
MR. GOBENA: Object to the form. Mischaracterizes the witness's testimony. You can answer.

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THE WITNESS: I did have responsibility for Medicaid. The federal government runs and manages Medicare day-to-day. And when you had a situation like you did for Medicare, I felt it was probably next to prescription drug reform, which was my number one priority going back in the government. And number two was probably fixing AWP, because it was a big fiscal and management and policy problem for the agency.
So I spent a lot of time trying to fix it. On Medicaid, I had equal interest but the single biggest Medicaid policy fiscal issue that we had was if -- was the states scamming reimbursement matches which I mentioned earlier, which was a multibillion dollar problem, state by state, with the states because they had a fiscal partnership between the federal and state governments. The single biggest policy problem there that I spent most of my time on was to trying to prevent the states from putting up air to match federal, and drawdown federal dollars without putting out state dollars.
Once we got to the point where we're

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that's -- I realize no time is good for you for this, but we'd certainly work with you on your schedule to find the best possible time to continue.

MR. HAAS: I object strenuously to the use of the transcript without having the opportunity to cross-examine or redirect on behalf of my client. There has been a number of comments made, testimony made with respect to Johnson & Johnson and its products. And clarification is needed. And absent that opportunity, I strenuously object to his testimony and will proceed accordingly.

BY MR. DALY:

Q. What's an FUL?

A. Federal upper payment limit.

Q. And do you have a working understanding of when it is that an FUL is supposed to be created for a drug?

A. I did three years ago. I'm not sure I can remember exactly how it's -- how it works, but it's essentially an upper payment limit for usually I believe a multisource generic drug. But I can't remember exactly what the rule is, but it used to be

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--

Q. Three or more?

A. Yes. I think it was 250 percent or I can't -- 250 percent or whatever the, I can't remember the rule.

Q. Do you remember what triggered the creation of FULs in terms of if there are three or more different drugs that are functional equivalents that CMS would then prepare or create an FUL for that, those three drugs?

MR. GOBENA: Object to the form.

BY MR. DALY:

Q. Is that -- I'm just trying to see if that jogs your memory?

A. I just can't remember precisely how it works. It's been three years.

Q. Well, you remember that it was something to do with if there are a number of drugs that can be full substitutes for each other within a basically the same drug?

A. Yes. It's the maximum amount CMS will pay for any of them.

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Q. Right. And that that's something that CMS was going to do?

A. Yes.

MR. GOBENA: Object to the form.

THE WITNESS: Yes. CMS had that regulation in place and I think they put out a new one this year as a matter of fact.

BY MR. DALY:

Q. And do you know why -- or do you know whether FULs were ever created for any of the drugs that the DOJ has sued Abbott for in this litigation?

A. I don't know. I assume so, but I don't know. I mean, Vancomycin is a generic, I think. So I assume there was an FUL, but I'm not familiar, I'm not specifically familiar with it.

Q. And sodium chloride is certainly a generic, right?

A. Yes. So I assume there is an FUL for all of them.

Q. Well, let me represent to you that there are not, and then my question would be, do you know why?

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MR. GOBENA: Object to the form.

THE WITNESS: No. I don't. I think before you get off that, I should clarify, I assume it's because they are infused drugs, and the FULs are generally pharmacy dispensed drugs for the most part. I assume that's the reason.

BY MR. DALY:

Q. Okay. But you don't know?

A. I don't know.

(Exhibit Abbott 196 was marked for identification.)

BY MR. DALY:

Q. Mr. Scully, I've handed you what we've marked as Exhibit Abbott 196 which is an August 10, 2001 memorandum to you from Michael Mangano, who is the principal deputy inspector general attaching an OIG report from August 2001. And did you receive a copy of this memorandum from Mr. Mangano?

A. I don't recall, but I'm certain I did.

Q. In the -- this document is entitled Medicaid pharmacy actual acquisition cost of brand name prescription drug products, is that correct?

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sure I probably agreed with it.
Q. Well, do you agree with it now?
A. Yes.
Q. If you just flip to the very end of this and maybe this will refresh your recollection, maybe it won't, but the last couple of pages are a letter from you to Janet Rehnquist. Do you see that?
A. Yes.
Q. And is that your signature up by the from box?
A. It looks like it might be.
Q. Okay. So it would appear that you got this and sent Ms. Rehnquist back a response?
A. Yes. But since I probably saw 4 or 500 documents a night before I went home sometimes, whether or not I read it or not is another question. But I'm sure I agree with the conclusion in there.
Q. Well, in a lot of cases, you relied on your staff to prepare letters and review things and work on responsive letters with you, correct?
A. Yes.
Q. And when you wrote a letter such as this,

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to Miss Rehnquist, you were speaking on behalf of CMS, correct?
A. Yes.
Q. In the last part of the response, in the very last page of the document, you indicate that it was your intent to follow up with the states and strongly encourage them to review their estimates of acquisition costs, do you see that?
A. Yes.
Q. And to follow up with them to ensure that their actions take those findings into account. Do you see that?
A. Yes.
Q. Did CMS in fact do that?
A. I'm sure we did. I talked to many states about paying more reasonably for drugs. As I said earlier, my general approach was not to have states pay fee for service amounts for drugs, because in many cases, the political pressure was not easy to get that done. It was always more effective in my opinion to hire a third party at-risk PBM, because they are much more likely to get lower prices for

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states for drugs. And states increasingly did that.
Q. On the -- if you go back to the letter from Ms. Rehnquist to you on the second page, do you see she indicates that in the second -- in the first full paragraph, last sentence, "unlike brand name drugs where reimbursement is predominantly based on a discounted AWP, reimbursement of generic drugs can be limited by a federal upper limit amounts that are established by CMS." Do you see that?
A. Yes.
Q. And was it your understanding that CMS was charged with responsibility to create FULs for drugs that met the requirements of an FUL?
MR. GOBENA: Object to the form.
THE WITNESS: I believe so. Yeah, Larry Reed who I mentioned earlier today is the guy who did that.
BY MR. DALY:
Q. And is it your experience that setting an FUL for a drug that qualified to be given an FUL had the effect of reducing reimbursement for that drug?
MR. GOBENA: Object to the form.

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THE WITNESS: You know, I do not -- it was never one of my primary policy issues to get involved in the process for setting FULs, so my general recollection is it was pretty wide range and there wasn't usually a big reduction as a result of FULs.
BY MR. DALY:
Q. Mr. Scully, I'm going to hand you what has been marked previously as Exhibit Abbott 108, which is an OIG report relating to omission of drugs from the federal upper limit list in 2001. And I would direct your attention to the last few pages which contained the CMS response signed by you, is that correct?
A. Yes. That is my signature. Yep.
Q. I wanted to direct your attention to Romanette number i of the report, which is the third page in. Under the executive summary. And I want to direct your attention to the second paragraph, which talks about the requirements for when CMS is to prepare an FUL for a given group of drugs. And I just ask you to read that to yourself, and then ask you if that's consistent with your understanding of

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the requirements for a creation of an FUL.
MR. GOBENA: Object to the form.
BY MR. DALY:
Q. Have you had a chance to look at that paragraph?
A. Yes.
Q. Is that consistent with your understanding of when CMS was to create an FUL?
MR. GOBENA: Object to the form.
THE WITNESS: Yes. I forgot the 150 percent number, yeah, earlier.
BY MR. DALY:
Q. Okay. And then what you just referenced in your earlier testimony, you said maybe it was 250 percent?
A. CMS came out with a new rule this year that it was 250 percent of a different calculation that I can't remember exactly how it worked.
Q. And in terms of when you were at CMS, the rule was 150 percent of the published price for the least costly therapeutically equivalent product plus a reasonable dispensing fee, right?

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A. I believe that's right.
Q. And again, did you -- you don't know why the drugs that DOJ has sued Abbott on in this case were not FULed is that correct?
MR. GOBENA: Objection. Asked and answered.
THE WITNESS: I don't know. I'm guessing because they were infused drugs, they were not in the calculations somehow.
BY MR. DALY:
Q. Is there some exception to the FUL calculation for infused drugs?
A. I don't know. I don't remember. Generally, in Medicare, there is a differential between infused drugs and, you know, outpatient drugs delivered to pharmacy. And I assume maybe there is some differentiation in Medicaid I wasn't aware of.
Q. But you're not aware of any exception from the requirement that CMS create an FUL for a drug that qualifies that's based on it being an infused drug, are you?
MR. GOBENA: Objection to the form.

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THE WITNESS: No. I'm not. I was minimally involved in this process as you can tell.
MR. DALY: Let's do this one here, Exhibit Abbott 095.
BY MR. DALY:
Q. Let me hand you what's been previously marked as Exhibit Abbott 095. And this is a September 2001 OIG report relating generally to the -- what we've called the DOJAWPs. And I wanted to direct your attention to the CMS comments at the end, they are the last couple of pages. And we talked about Ruben King-Shaw. That's somebody -- he was your deputy administrator?
A. Yes.
Q. And he obviously prepared the response here?
A. Yes.
Q. And did you have any discussions with him about the technical correction that he made in the last paragraph?
A. Last paragraph of his response?
Q. Yes.

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A. On this page or where? Oh, I see, "we appreciate the effort."
Q. The very last page of the response, page 2 of his letter. I'll read it.
A. I see it. No. I don't recollect having a discussion with him.
Q. Well, do you see that he says that the original report stated that the inflated AWPs have caused Medicare to overpay for these products. Do you see that?
A. Yes.
Q. And he asked that the overpayment language be removed. Do you see that?
A. I'm sorry. What have I missed? I thought he was correcting it.
Q. It's the second page. It's this paragraph here. Had you looked at that paragraph when I asked you those other questions, Mr. Scully?
A. No. The earlier question?
Q. Right.
A. No. I didn't see this, but Ruben had just come from being two weeks before the Secretary of

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Health in Florida, so I'm assuming since I don't discuss it with him, he probably didn't like the -- probably, he always felt this way, didn't like the IG taking shots at states, so he probably asked to remove it.

But we didn't discuss it, but it's very Rubenesque. I would guess that was the intent of the tone is he just didn't like the IG suggesting states are overpaying, so much more than any other factual basis. Much more than any other policy based factor. I think he probably just didn't like the comments about accusing the states of overpaying.

Q. Because CMS had approved their plans to pay whatever it was that they were paying, right?

MR. GOBENA: Object to the form.

THE WITNESS: Because it implies the states are making errors or overpaying, and Ruben had just been a state Medicaid administrator and was probably as aggressive as anybody in the country about trying to reduce drug prices. So I'm sure he resented that. Probably took it out for that result -- for that reason.

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BY MR. DALY:

Q. He resented the implication that the states were doing anything wrong, is that what you're saying?

A. The states were not effectively trying to negotiate the lowest prices, at least in his state, which is the way he thought, so I'm guessing this was a much more personal thing than a policy consideration at CMS.

Q. Although when he wrote this letter, he was speaking on behalf of --

A. He was.

Q. CMS, right?

A. I'm just saying that he had been -- I'm guessing from our previous letters with Mike McMullen, he had been deputy administrator for about two weeks, and I know from dealing with him as my deputy for two and half years, he had strong feelings about what the states -- states rights to run their own programs.

MR. DALY: Well, I've got probably three or four more areas to cover with you. It's not going

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to be all day or half a day or anything like that, but I'm not going to be able to finish it tonight, so I'm thinking that at 6 o'clock, I know a lot of people have to go. I know I have to catch a plane, so you know, subject to your prior comments, I think this might be a good time to conclude.

THE WITNESS: Is there any reason why other people can't stay longer, I mean, given the issue of -- I mean, it would be convenient for everybody's time, but it's extremely inconvenient for my time to come back for any more than I have to obviously. And if you have to catch a plane, is there any reason why other people can't ask questions, with the other counsel, co-counsel here?

MR. GOBENA: Why don't we go off the record.

MR. DALY: Off the record.

THE VIDEOGRAPHER: The time is 6:04 p.m. Off the record with videotape number 7.

(Recess.)

THE VIDEOGRAPHER: The time is 6:08 p.m. We are continuing with tape number seven.

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BY MR. DALY:

Q. Mr. Scully, I just wanted to follow up on something you gave in one of your last few answers which was when we were talking about average discounts below AWP that pharmacies for example and others were able to acquire drugs under the Medicaid program. We were talking about the averages and you said that there were a lot of high volume, low cost drugs which might skew that average. Do you recall that testimony?

A. Yes.

Q. And those are high volume, low cost drugs, that's where you would expect the larger spreads to be?

A. I just generally recollect that was the case. Some of the higher, the higher spreads were in low cost drugs.

Q. Okay. And the low cost drugs would include sodium chloride, dextrose and water?

MR. GOBENA: Object to the form.

THE WITNESS: I'd have to look. I don't remember those particular. I remember ipratropium

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bromide and Albuterol being the two kind of poster children for that.
BY MR. DALY:
Q. Do you recall sodium chloride, dextrose and water being low cost drugs under the Medicaid program?
MR. GOBENA: Object to the form.
THE WITNESS: I don't. I'd have to look at the pricing. I assume they are, but I'm --
MR. DALY: All right. I just wanted to get that. And did you have anything you wanted to say after your meeting?
MR. GOBENA: Yes. As Mr. Scully has indicated, he is prepared to proceed as long as possible tonight to get as much of the questioning done. So what I want to do is go around the room and ask each one of the defense counsel here representing various drug companies whether or not they are willing to continue going tonight, even though I understand Mr. Daly has to catch a plane, Mr. Cook is here. He could ask questions for Abbott if Abbott has additional areas of inquiry. But I'll let all of

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you speak for yourselves to state on the record whether you're willing to stay further tonight, so we can continue and complete as much of his testimony as possible.
MR. DALY: I mean, you can ask anybody whatever you want to ask them. I just have two things to say. One, there was no indication from you that this would be a one-day deposition. Number two, the court reporter has informed us they are not going to stay here all night. They have been at this now for however many hours it's been, and it's just not reasonable that folks, you know, have to continue and work 14 hours straight, or 15 or 16 or 18, or however --
THE WITNESS: Well, that's a misrepresentation by my counsel, then, because I very, very, very clearly and very directly told them that I want to start as early today as I could and go -- excuse me, and go as long as I possibly could today.
MR. GOBENA: It's no misrepresentation. Look, we don't know how long a deposition is going to

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take until you actually get into it. There's been a lot of, frankly, in our opinion, repetitive, redundant questioning going on today. But you know, there might be a disagreement about that.
But leaving that aside, we are willing to continue. We are not talking about going all night long until tomorrow morning. We can go for hopefully a few more hours at least, try and get some of the questioning in from Dey's counsel, from Roxane's counsel, you know, and try and get as much of it done as possible.
MR. ESCOBAR: Let me ask you this. Why is it that you're saying that? Is there no day in the next six months where we can all reconvene and do this in an orderly way?
MR. GOBENA: I'm not saying that, I'm just asking whether or not --
MR. ESCOBAR: Excuse me, are you saying that there is no day --
MR. GOBENA: Let me answer your question, Mr. Escobar. I'm saying -- what I'm asking right now is a different question. Are you willing to ask some

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questions now. I'm not saying there is no day or anything. I'm not taking a position on that.
MR. HAAS: But it's a moot point. We don't have a court reporter. I mean, correct me if I'm wrong, but there is no notice that this was going later than the standard number of hours today. People have their plans based upon that. We don't have a court reporter, and I don't understand the point.
MR. GOBENA: What are the standard number of hours. In our case, it says 14 --
MR. HAAS: There is nothing about going 14 hours a day.
MR. GOBENA: It doesn't say anything about going 8 hours or not.
MR. HAAS: In this case, have you gone 14 hours?
MR. GOBENA: No one's talking about going 14 --
MR. HAAS: I'm asking you. There is none.
MR. BREEN: Let me just interject here. Let's not get all hot under the collar. The bottom

UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF MASSACHUSETTS

IN RE: PHARMACEUTICAL INDUSTRY AVERAGE WHOLESALE PRICE LITIGATION	) MDL NO. 1456)) CIVIL ACTION:) 01-CV-12257-PBS) Judge Patti B. Saris) Magistrate Judge) Marianne B. Bowler

THIS DOCUMENT RELATES TO

U.S. ex rel. Ven-A-Care of the Florida Keys,Inc., v. Abbott Laboratories, Inc., et al.

No. 06-CV-11337-PBS

(Caption continues on next page.)

VIDEOTAPED DEPOSITION OF

CODY WIBERG

Taken March 14, 2008

Commencing at 9:13 a.m.

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A. Oh, yes, yes, indeed.
Q. We'll get to that in detail later, but could you describe that work at a high level of generality?
A. Well, basically, again, under federal law, states are allowed to set reimbursement rates for pharmaceuticals. And so since we managed the fee for service pharmacy program, we obviously had a lot to say about what those rates should be.
Q. And you -- did you work with the legislature and the legislature's passing of laws that related to dispensing fees and reimbursement formula?
A. That's correct. Unlike some other states, where Medicaid reimbursement rates can be set by the agency, by rule, in Minnesota, unless things have changed, and at least in the pharmacy area, and I think in most areas, the legislature establishes the rates.
MR. COOK: Mr. Wiberg, let me hand you what we have marked in previous depositions as Exhibit Abbott 19.
THE WITNESS: It's a copy of the

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complaint in this case.
MR. BLACK: I just want to see which case.
MR. COOK: It is the complaint that was originally filed or the complaint and intervention filed by the Department of Justice. And it's Abbott.
MR. BLACK: Intervention?
MR. COOK: It's the complaint and intervention. And for the record -- it was filed in March of 2006.
BY MR. COOK:
Q. Just as an initial matter, Mr. Wiberg, have you ever seen this document before, to your knowledge?
A. I'm not sure. Unless you've -- folks sent it to me, then I don't believe that I have, no.
Q. Okay. Well, actually what I'd like to turn your attention to is the very last two pages of the document that are labeled Exhibit 1. And it's a list of drugs.
A. Uh-huh.

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Q. And could you take a look at those drugs and tell me if you -- if you recognize those drugs?
A. The top one appears -- the top two appear to be cut off. But otherwise, yes.
Q. And does this appear to be a -- to describe them at a -- at a higher level of generality? Sodium saline solution, dextrose solution, vancomycin, and water.
A. Uh-huh.
Q. What kinds of drugs are-- are those?
A. At a high level, I think what you want to know is they're injectable drugs. They're drugs that are commonly used in -- in IV therapy.
Q. These wouldn't be the types of pills, for example, that you were dispensing when you were -- a community -- community pharmacist, right?
A. That's correct.
Q. And as we go along, and happy to have you -- you keep a copy of that. When I refer to the subject drugs in the federal case, I'm referring to the drugs that are here on Exhibit 1. These are the ones that are the subject of the government's

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lawsuit against -- against Abbott.
A. Uh-huh.
Q. Do you know what the allegations are that have been made by the Department of Justice in this case against Abbott?
A. In this particular case, no. Because I have not read this document.
Q. Are you familiar generally with the AWP litigation that's been going on for so many years in the country?
A. Yes, I have.
MR. FAUCI: Objection, form.
BY MR. COOK:
Q. What is your understanding of what that AWP litigation relates to?
MR. FAUCI: Objection to form.
A. I think my understanding is that the basic allegation is that pharmaceutical manufacturers either falsely reported information or withheld information about the true cost of pharmaceuticals that they, in fact, inflated average wholesale prices in an effort to win market share for their

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cost of dispensing prescription medications to Medicaid recipients." Do you see that?
A. Yes, I do.
Q. And that would be consistent with your general understanding of what Myers and Stauffer was doing for various state Medicaid programs, right?
A. Correct. I know that's one of their -- the things that they -- they did. I don't know what else they might have done.
Q. And then if you look down under Summary of Findings in this 2002 report, at the first bullet point there, it's in bold, on the very first page of the Executive Summary. "Myers and Stauffer indicates what it finds as the statewide median cost of dispensing weighted by Medicaid volume to be, right"?
A. Correct.
Q. And in here it shows it to be $5.95, right?
A. Correct.
Q. And that is almost mathematically in the middle of what you were saying earlier the

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Minnesota Pharmacy Association was pegging as -- as its cost of dispensing, right?
A. Yes. As I recall, they -- that's the -- the general range they were talking about. They may have even had a specific amount. But somewhere in that range is what I recall them claiming it to be.
Q. If I could turn your attention to page 23, and on pages 23 through 25, what I'd like to do is turn your attention to aspects of this report that looked specifically at the cost of dispensing for I.V. and infusion pharmacies as opposed to retail pharmacies. Do you understand that distinction?
A. Yes.
Q. Before looking at this, could you tell me, what's your understanding of the difference between an I.V. or infusion pharmacy and a -- and a retail community pharmacy?
A. Well, a -- sometimes there is no distinction, actually. Some pharmacies do both. But there are specialty pharmacies that are referred to as home health care pharmacies, or home infusion pharmacies that are closed-door pharmacies. They don't have

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customers walking in from the street. They don't fill prescriptions for oral medications, typically. Instead, they fill injectable drugs, basically. Normally, they actually have to prepare or compound these drugs. And these are dispensed to patients who are receiving intravenous therapy at home.
Well over a decade ago, maybe close to two decades ago now, as just a general part of cost-saving efforts, some of the -- the procedures that used to be done, first in doctors' offices or hospitals, then in outpatient clinics or -- or outpatient areas of hospitals, were gradually shifted to the home. So patients who were thought to be not so critically ill that they needed to be in a home were -- would get treat -- or excuse me, in a hospital, would get treatment at a home.
Q. Now, this move from hospital to home for these infusion therapies, first as a subjective matter, is it your experience that patients would rather be at home than in a hospital?
A. I think that depends on the patient. I -- I never worked in home infusion pharmacy. So --

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Q. From the Medicaid point of view --
A. Yep.
Q. -- as a pure question of economics, however, did you have an understanding of whether it was cheaper or generally more expensive for Medicaid to pay for infusion in the home as opposed to admission into the hospital?
A. To tell you the truth, if you look at the totality of costs, no. I -- I wasn't -- I really don't know for sure. One would assume that it's cheaper to pay for the nondrug costs outside of the ho -- you know, outside of the hospital. That the hospitalization would be more expensive than treating someone in the horne. That would be the assumption I would make, although I did not do hospital rates, so I don't know.
Q. Well, do you know if within Medicaid there was any policy considerations of preferring out of hospital treatment because to the program as a whole, it would save money over in-patient admissions? Or have other policy benefits, such as lack of infection, comfort to the patient?

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A. I would assume that's the case, but I can't say that for certainty, because, again, I didn't work on -- on the policy issues involving hospitalization versus home care when it went to those costs.
Q. So to the extent there was someone within either the legislature or the agency that was looking to -- to try to move patients from -- into hospitals or out of hospitals or into home care or out of home care, that would have been some other aspect of the agency?
A. Correct.
Q. Okay. Could you describe for me the -- well, let me back up. When one dispenses a drug in a retail pharmacy, it's typically pills, right?
A. It's oral medications, typically with a few injectables.
Q. All right. So -- and so it might include, like, the liquids that I would give my kids with the Tylenol suspension.
A. Liquids, capsules, suppositories, gels, ointments, emulsions, creams.

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Q. What generally goes into dispensing those types of oral medications?
A. The typical process would be that a -- for a new prescription, let's say, the patient presents at the pharmacy with a prescription -- well, back in those days. More and more, actually, the prescription is being electronically transmitted to -- from the clinic to the pharmacy.
But back in those days still, most of it was the patient would walk into the pharmacy with a prescription from a doctor, someone at the pharmacy would enter the data. That could be a pharmacist, it could be a pharmacy technician. Once the data was entered into the system, if the person was on some sort of insurance or in managed care, and therefore had a pharmacy benefit, a claim would be transmitted to -- either directly to the payer, in the case of our program, or more commonly, to something called a Pharmacy Benefit Manager. That Pharmacy Benefit Manager would do the sort of things I talked about before in terms of editing the claim. If everything was fine, the claim gets

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paid. The label gets printed, along with a receipt. If it is a cap -- excuse me, tablets, capsules, solid dosage forms, oral dosage forms, somebody counts it out, somebody labels it.
The pharmacist in -- in this state, and I'm sure all states then, by law, has to certify the accuracy of the prescription, particularly if somebody else entered the information. And once the -- and that involves comparing the actual written prescription with what's printed on the label and what's in the bottle to make sure that everything is correct.
Once that's done, the medication is bagged, the receipt's put onto it. And, again, if pharmacists are following the law in this state, when the patient comes into the pharmacy for new prescriptions, the pharmacist is supposed to go out and counsel them on their medication. That's -- that a typical process.
The only significant difference between that and the other sort of things out there is, obviously, for prepackaged creams and ointments

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that come that way from the manufacturers, bottles of eyedrops, there's no counting. The label just goes directly on the container.
Q. And when we talk about the -- you know, the 6 -- $5.50 to $6.50 or $5.95 cost of dispensing the product to the pharmacy, are you referring to that process, plus whatever overhead is involved?
A. Correct.
Q. All right. I know that you never worked in an infusion or I.V. pharmacy, but do you have an understanding of how the dispensing process is different for an I.V. or infusion pharmacy?
A. I would have a basic understanding, primarily because you can't graduate from pharmacy school without having done a hospital pharmacy internship. And I did work in the hospital pharmacy, and I was involved in compounding I.V. preparations as part of my training as a pharmacist.
Q. And did that process of compounding and preparing infusion or I.V. products to be dispensed, was it typically more involved, or less involved than dispensing oral medications?

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A. It's more involved.
Q. All right. Could you describe for me at a high level of generality how it's more involved, or what more is involved in that process?
A. Well, for example, drugs that are meant to be administered by I.V. infusion, in some cases, can be prepared directly by a manufacturer. There are certain drugs that, because of the way that they're handled, or because of preservatives or whatever, are stable. And then they can actually be dispensed pretty much directly, maybe with some minor reconstitution; adding something like normal saline into the drug. Other drugs are much more complex. So, for example, a -- what's known as a TPN or Total Parental Nutrition Therapy. These are very large volume I.V. bags in which multiple different ingredients are mixed together. Basically a source of protein, a source of sugar, multiple vitamins, different vitamins, like what are called electrolytes. So you could have many different things that go into one bag.
Now, what I'm not going to be able to do is

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tell you the advances in the last 25 years. Because when I did this, we did everything by hand. My understanding now is that the home I.V. infusion pharmacies and hospital pharmacies that do this for in-patients have automated devices that essentially you -- my understanding, having not actually seen these, is that you load the manufactured containers, and you do the calculations, and the device does the mixing.
Q. From a business point of view for the pharmacy, presumably the cost of dispensing would also include, I guess, the cost of that sort of machine, right?
A. Yes.
Q. And it would be -- I guess a typical business question to decide whether it's cheaper to pay for a pharmacist to do it by hand, or cheaper to go out and buy the machine for whatever it costs and have it done more efficiently, and perhaps more accurately.
A. To tell you the truth, the business consideration is probably whether or not to have a

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pharmacy technician do it. Pharmacists, in some places, probably directly do this themselves. But actually, pharmacy technicians probably do most of the actual mixing and compounding, and then the pharmacist is certifying for accuracy.
Q. Okay. Well, if I could turn your attention to page 23 of Exhibit 21, this is the August 2002 Myers and Stauffer report for Texas.
MR. COOK: And, again, just for the record, so somebody watching it or reading the transcript knows what we're talking about, I'm going to read just the second to the last paragraph there. And then ask you questions about it.
A. Uh-huh.
BY MR. COOK:
Q. Quote, The two most significant characteristics that affected pharmacy dispensing cost, were the provision of intravenous or home infusion solutions, and the provision of pharmaceutical compounding services. Our analysis revealed significantly higher cost of dispensing associated with the 53 pharmacies in the sample

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that provided these services, close quote.
Given your experience as the manager of the Minnesota Medicaid Pharmacy Program, and as a pharmacist, does that conclusion by Myers and Stauffer surprise you?
A. No.
Q. In fact, you would expect that I.V. and home infusion provision and compounding services would increase the cost of dispensing to a pharmacy, right?
A. Yes.
Q. And then if you turn to page 24, the next page over, there are three bullet points there where Myers and Stauffer, would you agree with me, lays out the reasons that pharmacists with whom they spoke gave for these costs being higher for a home infusion or I.V. pharmacy. Do you see that?
A. I do.
Q. And would you agree with me that summarizing these, Myers and Stauffer was told by these pharmacists, according to the report, that the cost of special equipment for mixing and storing the

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I.V. solutions was one factor, correct?
A. The costs of special equipment? That would make sense, yes.
Q. And then second is they're higher direct labor costs, because of mixing and manual activities to fill the I.V. -- I.V. prescriptions?
A. That would make sense as well.
Q. And that's the second factor named in the report, right?
A. Yes.
Q. And then the third was that -- and I'll just read this. Quote, A pharmacy may mix and deliver many dispensings of a daily intravenous solution from a single prescription, thus incurring additional costs spread over a smaller number of prescriptions, close quote.
Does that factor also make sense to you?
A. It does.
Q. Okay. And then if we go down to table 3.3, which is just a little bit farther down on the page on page 24?
A. Uh-huh.

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Q. -- do you see that Myers and Stauffer reports the unweighted mean cost of dispensing prescriptions for three different types of pharmacies.
A. I see that, yes.
Q. And then down at the bottom, they first refer to pharmacies that do not dispense intravenous or compounded prescriptions, right?
A. Correct.
Q. And Myers and Stauffers reports -- you obviously don't know if it's correct, but Myers and Stauffers reports an unweighted mean cost of $6.96, right?
A. That's what they report here, yep.
Q. Right. And then the next up, they report pharmacies dispensing compounded prescriptions but not intravenous prescriptions as $9.13, right?
A. That's correct.
Q. And then they report the unweighted mean cost for pharmacies dispensing intravenous and home infusion prescriptions is $41.75, right?
A. That's correct.

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Q. Now, compounded prescriptions as opposed to I.V. prescriptions, what do you understand the difference between those two types of prescriptions to be?
A. Well, many I.V. prescriptions are, in fact, compounded prescriptions, so I.V. prescriptions are often a subset of the general term, compounded prescriptions. I believe what they're probably referring to here would be -- well, they actually state it. They're referring to prescriptions that are compounded, but that aren't for I.V. use. So that could be anything, again, from ointments, creams, oral solutions. Some pharmacies even do capsules. Some that specialize in compounding pharmacy will even press out tablets. So there's a -- suppositories. There is a whole wide range of different types of products that can be compounded.
Q. All right. The magnitude of -- of these conclusions that Myers and Stauffer reached, are they consistent with your understandings when you were the manager of the Minnesota Pharmacy Program for the Medicaid?

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A. I'm not quite sure what you mean by that.
Q. Sure. Do these findings surprise you at all?
A. Well, I don't think I'd speak to the exact amounts here. Because again, we never did a cost of dispensing study. If the question is framed more, does it surprise me that -- that I.V. home infusion pharmacies have a higher cost of dispensing, and that compound -- that pharmacies that specialize in compounding other preparations have a somewhat lower cost of dispensing, then at the lowest costs of dispensing are pharmacies that don't do a substantial amount of I.V. or compounded prescriptions. That hierarchy doesn't -- does not surprise me.
Q. But the exact numbers for -- you know $41.75 or $6.96, you can't say whether it's right or wrong, because you didn't have the data, right?
A. We -- we didn't do that sort of study.
Q. The last column on that chart shows standard deviation.
A. Uh-huh.
Q. Now, I'm not a statistician, but do you have

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an understanding of what standard deviation refers to?
A. The only thing I can surmise -- I'm not a statis -- statistician either. Well, no, it wouldn't make any sense with the first one. No, I really don't. I don't know what they mean.
Q. As a general matter, do you understand standard deviation to refer to the range of --
A. Yes.
Q. -- of data within that set?
A. That's correct.
Q. And would it also not surprise you that pharmacies dispensing I.V. and home infusion prescriptions would have the widest range of costs, as opposed to retail pharmacies, which have a more narrow range of costs?
A. Well, given that they have a higher cost to begin with, I would expect to see a larger deviation, yes. There's just less room to deviate from $6.96, that they have reported here, compared to $41.75. What I don't understand is the $72.59. Is that supposed to be a range around $41.75? I

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don't know.
Q. All right. And would it surprise you that I.V. and home infusion pharmacies would have a -- a wider range of the types of things that one does as opposed to another does, as opposed to a community pharmacy, where most of them do about the same thing?
A. Yeah, that's -- that's a possibility. I guess, you know, it doesn't surprise me that there might be, again, a wider range of costs for -- for I.V. pharmacies, I guess. It would depend on exactly what -- what they're doing. There may be specialty -- or maybe you would call them subspecialty I.V. infusion pharmacies that deal with very critically ill people that have drugs that are more difficult to handle and to store and that sort of thing.
Q. And, of course, from a policy perspective at Medicaid, that sort of range presents a difficult policy question if you're trying to set a single price that fits everybody, right?
A. It would.

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Q. If you turn to the next page, at the very first paragraph, the second sentence, and I'll just read it for the record. "Based on our cost findings, it must be concluded that the costs incurred to dispense intravenous or compounded prescriptions are not representative of the costs incurred by a general pharmacy." Close quote. Is that also consistent with your experience?
A. Yes.
Q. And then if we turn to the -- to the footnote, you see footnote 11 on page 25? And I'll just read that for the record. Quote, Although typical dispensing fees reimburse less than the dispensing costs of intravenous pharmacies, they're generally able to break even, based on the margin allowed on ingredient cost reimbursement. Compounding pharmacies predominantly market their services to self-pay customers, and do not solicit Medicaid reimbursement for most compounding services, close quote.
Focusing your attention on the first sentence of that footnote, relating to I.V. pharmacies. Is

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that consistent with your experience as the direct -- as the Manager of Pharmacy Program at Minnesota Medicaid?
A. Actually, no.
Q. How so?
A. Well, one of the things I didn't mention earlier, because, you know, again, I've been out of this for a while. And I was thinking more in terms of -- of general -- our general reimbursement rate. We did not -- the rate that I used before for dispensing fees, $3.65, is not what we paid I.V. infusion pharmacies.
Q. What did you pay I.V. infusion pharmacies?
A. We paid them substantially more. And I inherited this. It was actually something I -- I personally thought we may have been paying them too much. And actually, tried to have a it changed. And rather than it being changed, it ended up being embedded in law. It had been something that one of my predecessors, I don't know how far back, had put into place. When I became aware of this, I actually asked the -- the person who was doing the

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pricing for compounded I.V. drugs where this reimbursement rate came from, and where it was in statute. She was a retired pharmacist that manually did these. And she said, well, that's the way we've always done it. And I went actually to get this -- tried to get this in law, so that we would have a statutory basis for making these payments. And my suggestion was to reduce that rate. But the legislature decided not to do that.

Q. Do you know what the rate was?

A. I am going to probably not get it exactly right. But it really depended on what was being compounded. We had one rate for what you might call standard I.V. drugs, which would include a drug like vancomycin, a relatively simple antibiotic. We had another rate for drugs that were used for chemotherapy in cancer patients because of the hazards associated with that and the extra difficulty in compounding those. We had the highest rate for the TPN solutions, those drugs that I mentioned before -- or excuse me, those nutritional solutions I mentioned before that are

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in large-volume bags, and where many things have to be mixed in there. I believe, and I may be wrong, but I believe we paid $8 per bag for the simpler products. We paid $13 per bag for chemotherapy products. We paid 30 -- something in the 30s, 33 is sticking in my mind here, for TPN products that were one liter or less, and 40 -- per bag. And we paid $44 per bag for TPN solutions that were greater than one liter.

Q. And you learned this how long after you became the Manager of this Pharmacy Program?

A. I don't know exactly. See, first when I worked for the Department, I was actually the Drug Utilization Review Coordinator. I'm pretty sure I didn't know then, because I wasn't involved in -- in the pricing issues at that point. So I don't know exactly -- I think probably sometime within the first year that I took over as the manager.

Q. And who was the person that explained to you this differential dispensing fee for these services?

A. Her first name is Marie, and -- Perreault, P-

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e- r- r- e- a- u- l- t-.

Q. Do you recall what Miss Perreault told you was the rationale for having a different dispensing fee for these pharmacies?

A. Well, the rationale was basically because there are increased costs for compounding I.V. solutions. I might add, in addition, we -- in addition to the dispensing fee, my understanding was that we paid separately for certain special containers that -- and I'm not an expert in I.V. home infusion pharmacy, but there -- in addition to the -- the sort of plastic bags you might see on a television medical show, there are special containers in which these preparations can be prepared. And some of those are much more expensive than just a simple plastic or vinyl bag. And so we paid extra for those, in addition. I don't know exactly how much we paid for those.

Q. And, as I understand it, you proposed that that be changed.

A. I had discussions with my management about that, basically saying -- the basic thrust of it

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is, look, we really need this in statute. I don't feel comfortable making these payments when, you know -- at one point, I think the department did -- I think that's where these came from. I never was able to track this down, other than what Marie told me. But I think at one point the Department had the authority -- authority itself to set rates, and it didn't have to go through the legislature. At some point, the legislature stopped allowing the agency to do that. And I think what happened is, when the rates were established in statute, nobody looked at this. That's what I think happened. And so Marie kept pricing them out at that level. And so most of my discussion with management was, this really needs to be part of our -- the governor's proposal this year, whatever year that was, because we really ought to have something on the books that authorizes us to make these payments.

Q. And what was the proposal?

A. Well, the proposal was just to -- to put it into statute, is what senior management decided to do.

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Q. But you said that you had proposed going to the -- the regular --
A. No.
Q. Okay.
A. I -- I actually never got to the point where I made a specific proposal to management. It was more general discussions about, I think we're paying too much. And --
Q. Now, why did you think you were paying too much?
A. Well, again, we're paying at that rate, just for the simplest things, not $8 per dispensing, as we're talking about here. We're talking about $8 per bag. Which gets at -- I think one of the comments that you referred to earlier. Where there might be multiple dispensings that might drive up their costs.
What I actually wanted to do at that point was -- was to try to convince management we needed to look more closely at it. That's why I really hadn't gotten to a specific amount, because we needed to look at whether that was realistic. I

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just had the sense, and maybe I would have been proved wrong, if we had studied it. But I had the sense that $8 per bag, and then especially with the TPNs, $44, $33 per bag was a lot. And plus, we did know, you know, even back then, that there was a spread between AWP and what the pharmacies were covering. So my thought was that if we have -- we don't know exactly what it is, because there is no pricing transparency, but the assumption is, they're -- they're making money on the ingredient side, and now we're turning around and we're paying them dispensing fees per bag, and in some cases, we're paying for extra, you know, special packaging. And I -- I had a general sense that that might be too much.
One of the reasons I believe -- remember I said before, I was not involved in -- I was involved in the pharmacy area. Someone else managed the home health services. And I did have some discussions with the woman, and I -- I will not be able to remember her name, because --
Q. You knew my next question was whether you

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remembered her name.
A. She -- she left the department not too long afterwards. But we did have some discussions, and I think one of the reasons senior management decided, yeah, we better get this in statute right now, until we figure out what to do, because you're right, this really ought to be in law if we're paying this out. But one of the reasons I think they didn't want to at that point cut reimbursement rate is, we had talked -- this other woman who had policy for home health care and myself, had started to have discussions about bundling. In other words, we would pay a per diem to the home healthcare companies, and out of that per diem, they would have to pay for nursing services, the pharmacy services, and any other ancillary services, as a bundled package. And that kept getting pushed to the back burner, first because that woman left and her replacement had to be trained. And then by the -- you know, the budget problems we had 2002 and 2003 hit, and there were, quite frankly, much easier ways to save money than

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-- than working on that, which was a very difficult issue to try to figure out.
Q. And so to bring it back to Exhibit 21, in the Myers and Stauffer report, where they were speaking to Texas I.V. pharmacists --
A. Right.
Q. -- where the Texas I.V. pharmacists may have told Myers and Stauffer, I'm not making a dispensing fee but I'm making more profit on the ingredient cost, in Minnesota you found out that the I.V. pharmacists were making it on both ends.
A. That was my impression.
Q. Okay.
A. Yep, indeed.
Q. What was the ultimate legislative resolution of this?
A. As I mentioned before, they simply took the rates we were paying, and put them in statute.
Q. And the I.V. pharmacists continued to be paid based upon the regular formula for ingredient cost, correct?
A. That is correct.

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Q. So that would be AWP minus some percent.
A. Yeah, which varied during the time I was there.
Q. Did you have an understanding that that formula, AWP minus whether it's 9 percent or 12 percent or some other amount, resulted in a higher profit for I.V. pharmacists than it did for community pharmacists?
A. At the time I was working there, no, I didn't. Because, again -- well, for a couple of reasons, I think. First of all, as I mentioned before, we had no authority to ask people what they were actually paying for drugs. We had no idea whether or not home infusion pharmacies might be getting discounts from manufacturers or from wholesalers. So, no. I really don't know if they were -- if they were liable to make more of a profit than a community pharmacy would, based on that formula.
Q. Okay. To the extent that the I.V. pharmacies were using more generics than branded products -- for example, sodium saline solution is probably

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about as generic as you can get, right?
A. Right.
Q. Would it be your understanding that the spreads as a percentage would be higher for those I.V. pharmacies than for a community pharmacy dispensing branded pharmaceuticals.
A. Assuming that we -- assuming that we didn't put a MAC on the product. And I don't recall if we put MACs on -- on saline or not, to tell you the truth. But if -- had we put a MAC on the product, then presumably, the amount that they were making relative to what they were paying would not have -- would have -- yeah, would have been -- the spread would have been reduced.
Q. How did you decide which drugs to MAC?
A. Well --
Q. If I can turn that word into a verb.
A. Yes. No, we use it as a verb. In fact, since we -- it's a state MAC. We sometimes talk about SMACing.
Anyway, the -- and certainly, pharmacies accused us of SMACing them with our reimbursement

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policies. But, anyway, the -- our primary focus was probably more on -- not on -- on infusion therapy. The primary reason being, remember, I managed the Fee for Service Pharmacy Program. And in Minnesota, the 200 or slightly over 200,000 people that were in that program, the ones that were left in Fee for Service were primarily disabled people. And of those, the -- by far, the predominant sort of disability was mental illness. So the amount of money that we paid on I.V. infusion drugs compared to what we paid on antipsychotics was -- I don't want to use the term minimal, because we paid a lot of money for those, as well, although I don't remember the exact amount. But we certainly paid collectively a lot more for other drugs. And so when you are managing a program, and you have to produce savings like we had to do in 2001, 2002 -- well, actually, right through today, I think they're still doing it. You -- you -- you target those drugs that -- where most of the money gets spent. So what we looked at -- again, were mainly the -- I would say the oral medications. And we --

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exactly how we did that depended on when I was there. When I started there, we had very simple language that essentially allowed us to establish a Maximum Allowable Cost on any drug that had at least one generic product available. My predecessor, in order to -- he was asked to come up with a 1 percent savings. So his proposal had been to do more retrospective drug utilization review. And as he put it, to re-establish the MAC program, although one had been in existence. I think he wanted to reinvigorate it, you might say. His idea was that in order to do that, you really had to have something in statute. So you had to have some sort of legislative proposal, and quite frankly, by the time certain individuals that were representing lobbyists that were representing brand name manufacturers got through with the legislative process, we ended up with less authority to establish MACs.
So at that -- so from -- I think that was done in '99. So from then until I could get that reversed in 2002, we could not establish a MAC for

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any drug that was already on the federal upper limit list. And there -- and CMS took a long time after generics became available to put those generics on the federal upper limit list. So that's one thing we couldn't do. We also had to have the brand name, plus at least two generics.

After 2002, when I got that language reversed, we went -- we again had the authority to establish a MAC on anything that had at least one generic. And so that's what we did. As drugs went off patent and generics were introduced, as soon as those drugs were out in the market, we would MAC the products.

Q. We'll come to it in more detail in a little bit, but you refer to the legislature and influence from affected constituencies affecting eventually legislation, right?

A. Yes.

Q. Was it a political policy decision in Minnesota how much it was that Minnesota Medicaid was paying for prescription drugs?

A. A political -- what's a political policy

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decision?

Q. You're right.

MR. BLACK: Good question.

BY MR. COOK:

Q. I can ask that better. The amount that Minnesota Medicaid was paying for drugs at the end of the day was the result of the political process. Is that a fair summary?

MR. FAUCI: Objection.

A. Well, it was set by the legislature. The legislature consists of politicians. That's the way it worked in Minnesota. It was not a regulatory or bureaucratic decision. The rates for all Medicaid payments were set by the legislature.

Q. Is this a good time for a short break --

A. Yeah.

Q. -- since we're coming to the end of another tape?

A. Sure.

MR. COOK: We can go off the record.

VIDEOGRAPHER: We are going off the video record at 11:19 a.m.

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(A brief recess was held.)

VIDEOGRAPHER: We are now back on the record. This is the continuing videotaped deposition of Cody Wiberg, taken on March 14th, 2008. Time now is approximately 11:26 a.m.

BY MR. COOK:

Q. Mr. Wiberg, if I could turn your attention back to Exhibit 19, it's the -- the complaint with the list of subject drugs on it.

A. Okay.

Q. In what circumstances -- we started to touch on this a minute ago with the managed care versus the fee for service. But in what circumstances would the fee for service portion of Minnesota Medicaid pay for these products?

A. Well, directly -- there would be two ways. It would be direct and indirect. To the extent that the Medicaid program paid for anyone who was hospitalized as an inpatient, that would be one way, which I had nothing to do with, because that's all essentially a capitated arrangement based on what are called DRGs.

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In terms of the outpatient setting, we would pay for these -- probably primarily to home I.V. infusion pharmacies, or at least they would be the pharmacies that would be most likely to dispense these sort of products.

As I believe I mentioned earlier on, there are some pharmacies that are a hybrid. I mean, there are some pharmacies, particularly in outstate Minnesota, where the -- the larger home I.V. infusion pharmacies may not have a presence, or where the pharmacist thought that they could compete locally because of the local reputation, or whatever reason. There's a combination. They run a community pharmacy, and they also have facilities to do home I.V. infusion. But my -- my guess would be, and it is a guess, but -- because I didn't look at these specific products to see who exactly -- which pharmacies exactly we paid for, but it would make more sense that we paid for more of these for home I.V. infusion pharmacies.

Q. Would there also be circumstances in which those particular products would be paid in a

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physician-administered setting?
A. Oh, yes. Indeed.
Q. Starting first with the hospital setting. Again, just to exclude it, you mentioned DRGs, diagnosis-related groups?
A. Right.
Q. Do I understand that correctly to be a single payment that a hospital would receive, based upon the diagnosis of the patient?
A. That's my general understanding. Again, I was not an expert in that, but that's my general understanding, is they get essentially a per diem amount based on the diagnosis of the patient.
Q. And so if Mr. Black here went to the hospital because had he had had a heart attack, and he got a bag of saline as part of that, the hospital wouldn't be paid anymore or separately because he got one bag of saline or two or three, right?
A. That's my understanding.
Q. All right. Now, the I.V. pharmacy we've talked about already, right --
A. Uh-huh.

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Q. -- is a closed pharmacy that would prepare it and dispense it to whether it's a home health agency or nursing home or some other entity that would administer the drug. Do I have that correct?
A. Basically. My understanding is some of the home health care businesses really own both components. They -- they own the nursing component and the pharmacy component. So it may all be within one corporate umbrella, I guess.
Q. And the same might be true, say, for a nursing home.
A. Possibly. Possibly. It's a possibility. I think it's more common -- well, these days, there are -- in Minnesota, there are several large nursing home pharmacy chains. I don't know if they're owned by corporations that also own nursing homes or not. But there are several large chains that have -- national chains that have a presence in Minnesota that -- that do a lot of nursing home business in this state. How much of the I.V. infusion business they do for nursing homes, I'm not quite sure about that.

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Q. And then the final context was being administered by a physician. Could you explain that method of paying for products like this?
A. Yeah, that -- that is different. The -- in certain circumstances, at least when I was there, and this possibly may have changed since I was there. But when I was there, we did pay physicians, outpatient surgical centers, facilities like that, if they were administering drug -- and emergency rooms. If they were administering drugs in an outpatient setting, they could bill separately for the drugs. When I got there, and, again, I'm not quite sure how this was established. It was before I was there. We were paying flat AWP. And, again, we were looking for cost-cutting measures. So what I proposed at the time, or -- well, there were two different proposals over the years. The first proposal I had -- I'm guessing 2001, 2002, was to go to AWP minus 5 percent. That was selected, because at that time, I believe that's what Medicare was paying. Now, my mistake in crafting that bit of -- of legislation was

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actually specifying AWP minus 5 percent. What I should have done then, and what we later did do, is reference the federal rate. So right now, the -- unless it's changed since I've been there, right now, the language basically says, Medicaid will pay for the outpatient administration of drugs at whatever rate Medicare pays for.
Q. And you understand that now to be average sales price plus 6 percent, plus some sort of a professional fee.
A. Now that you mention it, that -- that is the formula. I -- I wouldn't have been able to recall that, but yes, I do recall ASP plus 6 plus a fee.
Q. Now, when one of these products, one of the subject drugs was dispensed by a pharmacy, what sort of a form would Minnesota Medicaid receive in order to pay the claim?
A. When it's dispensed by a pharmacy?
Q. Yes, sir.
A. A pharmacy claims -- well, that evolved, too, at the time I was there.
When I first started, I think most of those

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claims came in on paper. And it was a pharmacy claim, basically. We -- we did our own in-house billing. We did not hire a fiscal intermediary or whatever to process our claims. When the pharmacy world in general moved to a new claims processing standard that's called NCPDP 5.1, NCPDP 5.1 has -- has a provision in it so that pharmacies submitting a claim can indicate that it's a compounded claim, and there are multiple lines where -- NDC or the drug code for each drug can be listed. And on each of those lines, you can list the NDC, you can list the quantity you used if you're compounding, and then our system was able then to look line by line, and calculate, yes, we'll pay for this product, because it's -- it's made by a rebating manufacturer. No, we won't pay for the next ingredient. Yes, we'll pay for the final three. And --

Q. Or it's MACed.

A. Or it's MACed -- well, at whatever rate we paid. Either at the normal rate or a MAC rate, whatever. It calculated the ingredient

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reimbursement, line by line, including -- you know, there were some lines that would be rejected. If we paid for everything, if we paid for every drug in every line, it would add those all up. It was sophisticated enough to know how many bags were submitted, so it could properly do the 8, the 13 or those other fees I mentioned. And it would simply pay the claim. If we rejected one line, we would pend or stop the claim. The pharmacy, in essence, would get a message back that would say, this is what we're willing to pay. If that was some ingredient, like normal saline, that was relatively cheap in a small quantity, like maybe they only added 100 milliliters, they might actually decide -- cheap for them to purchase. They might actually decide, we're fine with the rest of the reimbursement. And then they could send a code back that said, yeah, pay us. If it was a more expensive ingredient, they might say, wait, well, we're gonna lose money, and then they would not send a claim back and it would become a noncovered service. So that's how it evolved over time.

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Once that happened, we also covered a much broader range of compounded products.

Q. And these pharmacy claims forms, they're the forms that would have the usual and customary charge, and the description of the product dispensed by NDC, National Drug Code, correct?

A. Correct.

Q. When a physician administered a product such as those listed on Exhibit 19, what sort of form would -- would he send in?

A. My understanding would be what -- when I started, was called a HCFA 1500, now called a CMS 1500, so -- since HCFA is now called CMS.

Q. What sort of information would be included on that form about the drug that was administered?

A. What would be there are what are known as HCPCS codes.

Q. What are HCPCS codes?

MR. COOK: And for the court reporter, that's all caps, H-C-P-C-S.

A. You know what the acronym stands for, I don't know anymore. But HCPCS codes are codes that

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physicians, outpatient facilities, a wide variety of nonpharmacy providers, use in their billing. There are a huge number of HCPCS codes. I mean, the HCPCS manual is at least that big (indicating.) The ones in pharmacy that we were most concerned about were called J codes, because they started with J. There were some other drugs that weren't J codes, but most of them were J codes. J codes, or HCPC codes in general, at that time were not -- they're not tied to a specific product. What they are -- as an example, using your list of drugs here, they're made -- and I'm not sure if this is true, because I haven't looked at a HCPCS manual in two-and-a-half years. But there may be a code, you know, J something or other, J 1251 or whatever, that says, for 100 milliliters of dextrose solution, for that quantity, the HCPCS code is for that quality, 100 milliliters dextrose Liposyn solution. And so that would be a HCPCS code.

Q. Now for the NDC claim on the pharmacy side, you could go look up the published AWP for that NDC at First DataBank, right?

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A. We -- we could look it up. That's not how we did it, but we could look it up.
Q. How did you do it?
A. When I started there, we received -- was it monthly or biweekly? I think it was monthly. We received monthly data tapes from First DataBank.
Q. So the computer would go look it up.
A. The computer would go look it up.
Q. Okay. With the ND -- with the J codes, with the HCPCS codes, how would the program go about determining what the payment amount would be for a particular J code?
A. Well, there were actually -- although we were involved in the policy setting, there were -- there was another unit, again, with -- within DHS, that did rate settings, that were responsible for actually entering the -- the rates data. Presumably, what they were doing, what they should have been doing, in the case of pharmaceuticals when I started, is they would have been trying to determine what AWP was. I think, actually, as I recall what they were doing, though, is they --

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even before it became part of statute, they were looking at what Medicare was paying and trying to figure out what Medicare was paying, and how, since Medicare, I think, was taking AWP minus 5 percent off, I -- I assume they were adding that 5 percent back in, because we were paying a flat AWP. So I think they were relying -- for their data, I think they were relying on -- on Medicare, I think.
Q. But a single J code would include drugs from several manufacturers, right?
A. It could. Or it could be one to one.
Q. Right. For a drug such as sodium saline solution or dextrose, would it be your understanding that a physician would get the same payment, regardless of which manufacturer's --
A. That's correct.
Q. -- self solution he used.
A. That's correct. At that time.
Q. Well, has it since changed?
A. I'm not sure if it has changed, but the systems are getting sophisticated enough in -- we had discussions -- actually, they were national

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discussions among my counterparts at meetings we'd attend about having physicians, to the extent possible, bill by NDC code. For the primary reason, as I mentioned before, one of the things we did is we collected rebates. And prior to the time that I started, maybe even for the first year or so -- oh, definitely in our state for maybe a year or two, or maybe even a little bit more after I started, we weren't collecting rebates for drugs that were administered by physicians and billed by HCFA, or CMS 1500 forms. And my understanding is, prior to becoming involved with the Medicaid, most states didn't do that. Then some states took a closer look at the federal language. And what the federal language talks about is collecting rebates on outpatient drugs. It doesn't say outpatient drugs dispensed by a pharmacy. So some other states first started collecting rebates for those drugs, and that's actually one of the proposals that I came to our legislature with. And we started doing that. And at first, what we had to do is, we had to build what we called a crosswalk, which meant

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that we only collected rebates for those drugs where there was a one-to-one match between the NDC and a HCPCS or J code.
Q. That might be a J code that has only one drug in it.
A. Correct.
Q. So you know that --
A. That had to be from that manufacturer, correct.
Q. Got it.
A. I think there were other states, and I don't recall if they did it or not. I think there may have been other states that were trying to -- based on claims that they did get, sort of proportionally assign the rebates to the various manufacturers. Minnesota never -- never did that. But that was one of the reasons why Medicaid pharmacy managers, like myself, were very interested in seeing the -- the billing standard change so that physicians, other outpatient facilities, would have to bill by NDC so we could collect the rebates in those products, as well.

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copies of Red Book, but actually, we typically would -- we might look to that to make sure that there were still multiple generics available. We might look at that just to look up an NDC number, if we were doing clinical research, and we want the to look up something about the drug or something like that. But we relied on the data we got from First DataBank. This -- this data was automatically loaded into the computer, goes in at the end of the day, runs overnight. And the -- what -- that First DataBank does not provide just pricing data. All of the data that's needed to do those clinical pharmacy edits I mentioned comes from them, as well. The drug, drug interactions, that sort of thing. So, again, there -- there was some consideration of doing something like maybe Texas did, but the trade-off in that is, you would have to hire a small Army of people to recreate what First DataBank did.

Q. Were you aware at the time you were Manager of the -- the Pharmacy Program in Minnesota that manufacturers had reported direct prices that would

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be published in some of these compendia?

A. I -- now that you mention the term "direct price," yes.

Q. Did you have an understanding of what direct price was?

A. To tell you the truth, no.

Q. Did you have any understanding that it was similar to the usual and customary rate; the amount that a person with whom you have no contract, no negotiations, a cash purchase for a single unit would pay for that product?

MR. BLACK: Objection to form.

A. No, not really.

BY MR. COOK:

Q. Okay.

A. It's not a -- it's not a price figure that we used in any of our payment methodologies, so --

Q. All right. Did you have any understanding about the difference between what manufacturers were charging for a product such as sodium saline between a single bag of saline sold directly to a customer versus 20,000 units sold to a hospital or

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a large infusion pharmacy?

A. Specific knowledge, no. But the assumption would be that there would be volume discounts.

Q. And you're familiar with the -- the term, "the commodity," right?

A. Uh-huh.

Q. Would sodium saline, dextrose, would those -- water, would those be products you would consider to be commodities?

A. Well, we sure -- we didn't really think of drugs of any sort, if they were approved as drugs, as commodities, per se. That's not the way we looked at them.

Q. All right. Certainly closer to a commodity than a branded, patent-protected drug, correct?

A. Well, no, I wouldn't -- I wouldn't say that's necessarily correct. I mean, the one time I actually heard them use -- the word "commodity" used, because that's not a word I used in connection with administering the Pharmacy Program. The one time I actually heard someone refer to a drug as a commodity actually came from a brand-name

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manufacturer. It was a manufacturer of one of a group of drugs that are known as proton pump inhibitors, the most famous of which is the little purple pill, Nexium, that's advertised ad nauseam on TV for nausea, among other things. But proton pump inhibitors was the first category of drugs -- before we started doing a preferred drug list, it was actually the first category of drugs that showed us the potential for significant savings if we did a preferred drug list. And, I'll admit, we sort of stumbled into it.

Q. How did that happen?

A. Well, I inherited a prior authorization program from my predecessors that was basically ineffective. The one group of drugs where my predecessors had made an attempt to do prior authorization was failing, and that was with proton pump inhibitors. The Drug Formulary Committee, both before I started there, and for the first year or two after I was there, insisted that physicians be allowed to prescribe a proton pump inhibitor without prior authorization for the first four to

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considerations at the time.
So if you wanted to make it -- and you would have three choices, basically. You could either make it -- try to make it as close as you could to revenue-neutral. You could try to recoup savings. And therefore, you -- you're going to set the dispensing fee maybe not as high as you would if you were going make it revenue-neutral. Or you could try to actually pay providers more money then, and you would set it a little bit higher. But I basically -- when this came out, and at that conference I mentioned, where -- where Mr. Lup -- Mr. Lupinetti and I both were presenters at a conference. We were talking about different issues, and I was not talking about this particular issue, per se. But he was talking about this issue. And I did basically bring up that, you know, you really have to understand how the pharmacy reimbursement system works. You can't -- you have to understand that there's two sides of the equation, that the dispensing fees are kept artificially low. That if you just reduce the

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ingredient reimbursement to actual acquisition cost, and don't do anything with the dispensing fee, there's at least the possibility that you're going to have access problems for patients, because pharmacies at that point might drop out of the system.
Now, there's an argument that it really wouldn't make much difference, because the very large national pharmacy chains don't necessarily make their money on the prescriptions. They make the money on what you buy in the front end of the store. And if they use pharmacy sales or prescription sales as a loss leader, they'll still sign up for Medicaid.
Q. There will be a retail pharmacy, correct?
A. Yeah.
Q. Not a closed pharmacy like an infusion pharmacy.
A. No, no. So there's that argument. But anyway, the argument I made is that you can't -- you can't look at one side of the equation. You have to look at both sides of the equation. You

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have to understand that we know, and this is a serious aspect of ain't what paid -- "ain't what's paid." We know AWP, "ain't what's paid." But if we move towards more transparency and we get closer to reimbursing on the ingredient side at what providers actually pay, then we have to look at the dispensing fee side in the case of pharmacies, because we've always kept that below what we think the true cost of dispensing is to make up for the fact that there is some money being made on the ingredient side. So to the extent, again, that you start paying people a dispensing fee or a total reimbursement that does not even get back the cost of the drugs, plus the cost of labor and the computer systems and the lights and all that, you could have providers stop -- you know, start dropping out of Medicaid. And then this creates an access issue for very poor people. So -- yeah.
MR. BLACK: Objection, form. Nonresponsive.
BY MR. COOK:
Q. And so would it be your understanding that if

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we were -- if one were to go to this ideal world in which AWP actually represented acquisition costs, the Medicaid programs would no longer use an AWP minus a percentage.
A. To the extent that -- that whatever was used, revamped AWP or an ASP or an AMP, whatever you use as a basis of a cost reimbursement, or -- or excuse me, ingredient reimbursement to the extent that that closely reflected the average actual price the providers paid, then you would -- right. You would no longer be taking percentages off.
Q. And, in fact, are you familiar with the manner in which the federal legislation has changed the calculation of federal upper limits to be two-and-a-half times the Average Manufacturer's Price?
A. If that's a recent change within the last two-and-a-half years, I wouldn't know.
Q. And we've already talked about Medicare paying ASP plus some percentage, correct?
A. 6 percent, I believe it is, yep.
Q. Once you learned what the actual amounts were

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that NAMFCU was distributing as these new AWPs, or First DataBank was distributing, did you yourself take any efforts to go and look at invoice pricing to compare the new AWPs to invoice pricing?
A. Yes, I did.
Q. Could you tell me about that?
A. As I mentioned, at the time I was still moonlighting in the community pharmacy. So the next time I worked a weekend at the community pharmacy, I took my list of 476 drugs and looked at the prices that were at least listed as being the prices that that pharmacy chain paid for the drugs. Again, taking into account that they may have had additional rebates that I was not aware of at all. And just looking at -- at some of those drugs. That's why I became concerned. Because the AWPs, the so-called Medicaid AWPs that were reported did, in fact, in many cases -- not all, but in many cases, were about what this chain pharmacies supposedly was paying for these drugs. That's why I became concerned about them now taking an additional 9 percent off in terms of doing the

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reimbursement.
Q. Do you recall receiving any complaints from home infusion or I.V. providers about --
A. No.
Q. -- these new AWPs?
A. Not specifically. There were complaints, as I recall. There were a smattering of complaints, I'd characterize it as, from pharmacy providers. But I don't recall which individual ones they were.
Q. Let me hand you what we've marked in a previous deposition as Exhibit 492.
If you would give me just a moment.
And for the record, Exhibit 492 is an email from David Shepherd in Virginia --
A. Uh-huh.
Q. -- to Martha McNeill in Texas, dated June 23, 2000, forwarding an email from you from the prior day.
A. Okay.
Q. It looks like it was sent to the National Medicaid Pharmacy Administrators LISTSERV. Do I have that correct?

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A. That's probably correct, yeah.
Q. And if you look at the end, it indicates, NMPAA-talk.
A. Uh-huh.
Q. Was that the LISTSERV that you were referring to?
A. Yeah, I believe so. Yeah.
Q. And it's at ListBot.com.
A. Uh-huh. Again, I never paid attention to actually what the LISTSERV was called. I'm not even actually sure who exactly ran it. But yeah.
Q. And did you know David Shepherd and Martha McNeill?
A. Yes.
Q. Who were they?
A. David Shepherd is, as the email indicates, worked for Virginia. And my understanding is he was my counterpart in Virginia. Martha McNeill worked for Texas. I don't know if she was actually the Pharmacy Program Manager in charge of all of that, but she certainly was heavily involved. She was a pharmacist that worked for Texas Medicaid on

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pricing -- on doing the same sort of things that I did.
Q. And David Shepherd also was a pharmacist?
A. I think so. I'm not quite as sure. But --
Q. Did you find Mr. Shepherd and Miss McNeill to be as knowledgeable as you were about the issues relating to drug pricing we've been discussing here today?
MR. FAUCI: Objection.
MR. BLACK: Objection, form.
A. Well, you know, my interaction with them was on a LISTSERV in Massachusetts like this, occasionally seeing them at national meetings, and things like that. In casual conversations, they -- they -- I could converse with them. They seemed to understand what I was saying. Their actual level of expertise I don't think I can judge.
BY MR. COOK:
Q. If you look to the text of your email, you're forwarding the text of an email that you had sent to First DataBank the prior week, correct?
A. Well, can I read this?

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Q. Oh, please. Take your time. Take your time.
A. Yeah, this is from 2000.
Q. Yes, sir.
A. I don't remember emails that long. I don't remember them eight weeks ago, let alone eight years ago. 420 -- 476. I could be wrong. I was probably more accurate back then.
Q. In fact, Mr. Wiberg, why don't I give you Exhibit 380, also --
A. All right.
Q. -- which is a copy of an email that you appear to have sent. And I'll give you time to read both of those at your leisure.
A. Okay. I've read this first document.
Q. That's Exhibit 492, correct?
A. Yes.
Q. Do you recall that email?
A. Now that I've read it, yes, I do.
Q. All right. And do you recall having those thoughts and expressing them to your fellow Medicaid pharmacy administrators at the time?
A. I did send the email.

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Q. Yes.
A. And I --
Q. But it was a fair reflection of what you thought at the time.
A. It's a fair reflection of what I thought at the time, it's a fair reflection of what I still think.
Q. The first thing I would like to point you to in this email is the -- on the very first page, and the first paragraph of your email to First DataBank.
A. Uh-huh.
Q. It begins, "since early May."
Do you see that?
A. Let's see.
Q. It's about five minutes down.
A. Yes.
Q. And I'll just -- for the record, it reads, quote, Since early May, FDB has been reporting to state Medicaid agencies, quote, AWPs, close quote, for approximately 428 NDCs that are the different than the real AWP that is really being reported to

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your commercial customers. Close quote.
When you referred to real AWPs, you were referring to the AWPs that had traditionally been published in First DataBank, correct?
A. Right.
Q. And in the next sentence, you indicate that you've discovered that these new AWPs that are being reported are at or below actual acquisition costs, right?
A. Correct. That's what I put in the -- the email, yes.
Q. Right. And you -- and you abbreviate that with the all caps AAC.
A. Uh-huh, correct.
Q. Was that an understood term, AAC, for Actual Acquisition Cost at the time?
A. I used it. I -- I think it was fairly commonly used.
Q. And it was distinguished from AWP, correct?
A. Yes.
Q. Would it be fair to say that AAC is what AWP would be if AWP really were an average of wholesale

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prices to pharmacists?
A. Assuming that AWP was an average of the actual net costs to the pharmacy, net any sort of discounts that they -- they received, yes. You know, AWP, in -- when you put it in those terms, yes. It would be actual acquisition cost.
Q. And if you go down just a little bit farther, you indicate to First DataBank, or you indicated to First DataBank that there were pharmacies that had told you that they would stop supplying some of these 428 products if the new AWPs remained in effect, correct?
A. Correct.
Q. And was that true?
A. As far as I know, it was true. Again, the specifics of which pharmacies or which type of pharmacies, I don't know. I do recall getting calls from both pharmacy providers and also from organizations like the Minnesota Pharmacists' Association that represented pharmacies. And I do recall individuals telling me that, you know, they were losing money, and they could not continue

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supplying the products at that price.
Q. And then if you go down just a little bit farther, you write, quote, While the legislators did not define AWP, we believe that their intent was it use AWP to mean a single estimate of wholesale price as published in a compendia, such as Red Book or by First DataBank, closed quote.
Do you see that?
A. Yes, I do.
Q. Did you understand the legislators' intent of using the word "AWP" to refer to the published AWP in the compendia?
A. That was my understanding of what the intent probably would be.
Q. If you turn to the next page, you indicate in the first full paragraph that the providers who had contacted you ranged from independents to chains to specialty infusion pharmacies who were complaining. Do you see that?
A. I do.
Q. Do you recall any of the details of any of the complaints you received from any of those

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pharmacies?
A. No. Just as I've just mentioned, I recall getting complaints. If I wrote that, I believe it to be true.
And -- but remembering the details of what may have been five-minute phone conversations eight years ago, sorry, I just don't.
Q. And in the next paragraph, you indicate that, as you put it, almost everyone who is familiar with pharmacy reimbursement knows that AWP is "ain't what's paid," right?
A. Yes.
Q. And back then also, almost everybody who is familiar with pharmacy reimbursement knew that AWP was "ain't what's paid," right?
A. Yes.
Q. Okay. And then at the end of that paragraph, you indicate that the spread between AAC and AWP is taken into account when determining what to pay for a dispensing fee, right?
A. That's correct.
Q. And that's what we've just been discussing

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for a couple hours, right?
A. Well, for -- after -- after the lunch break here, yes. I went through this, yeah.
Q. And if you look down at the next paragraph after the block quote, you state that, quote, In fact, when pharmacy organizations have sought an increase in dispensing fees, the AWP spread has been pointed out to legislators, closed quote.
Do you recall that in negotiations with the legislature about dispensing fees, the fact that there was profit on the ingredient cost was pointed out as a reason not to increase dispensing fees?
A. Yes. This is back in 2000. And I don't recall so much the discussions back then, because that was before we were trying to lower fees. And I don't recall if there were efforts to try to increase fees. I know there had been. And there may have been, I just simply don't recall.
And there -- there may have been -- there were -- and, again, exactly when all these legislative proposals came into place -- it's hard to remember now, because the time I was there, every year there

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were a half a dozen to a couple dozen pharmacy-related bills. So it's very possible that some legislator in 1999 and 2000 was trying to get reimbursement increased. There was one effort -- I don't remember exactly what it was, where one legislator wanted every independent rural pharmacy in the state to get an increase.
But -- so exactly when the discussions happened, I don't know. But we had numerous discussions with the key -- health care-related legislators about this issue.
Q. And you advised those legislators that pharmacies had a profit margin built into the ingredient cost of the reimbursement formula that made up for the fact that the dispensing fee was not sufficient to cover costs plus a profit, correct?
A. That would be correct.
Q. If you go down to the -- a little bit farther, at the very last two sentences of that paragraph, it reads, quote, If the AWP spread disappears, the dispensing fee may have to be

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increased, especially for many of the 428 drugs currently in question. Many of these drugs require some type of compounding or other preparation, close quote.

Do you recall, whether, in fact, many of the drugs on the NAMFCU list were infusion drugs that required compounding?

A. I believe many of them were. I don't recall -- the specific details. Obviously, I got the number incorrect. I thought it was 476. But, as I recall, there were a lot of drugs that would have been used in I.V. compounding.

Q. In fact, I'm going to hand you a copy of Exhibit 587, which is from a related program. It's a Medicare program memorandum. Do you recall that Medicare at the time was also looking to go to use these new DOJ AWPs?

A. I may have been aware of it. I didn't focus as much on -- on Medicare and -- I mean, this particular document doesn't look familiar immediately. But I -- I may have seen it. But I was obviously more concerned with Medicaid than

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Medicare.

Q. And if you look at attachment 1 to Exhibit 487, it's a list of drugs with an Average Wholesale Price listed for each of them.

A. Where is that? Started on page 4?

Q. Yes, sir.

A. Yes, I see that.

Q. Does that look familiar -- does that look similar to the list of DOJ or NAMFCU AWPs that you received back in 2000?

A. I'll just take a look at this. It -- I guess it -- there's some drugs I recognize as being on here, like the acyclovir.

Q. Uh-huh.

A. So it -- it might be. But, you know -- I haven't seen that list in many years.

Q. Do you -- do you recall sodium chloride, dextrose and vancomycin being among the types of drugs that were included on the NAMFCU list?

A. Not specifically.

Q. Certainly, those would be drugs that would fall within the category of drugs that required

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compounding or other preparation before being dispensed, correct?

A. Typically. And there are -- sometimes, depending on exactly what it is, you can do some of these drugs. For example, dextrose with sodium chloride. On page 9, the fourth drug down appears to -- or the fourth product down appears to be dextrose sodium chloride, 5 percent dextrose, sodium chloride, 0.9 percent. And, again, if you're watching those medical shows on TV, and you see the doctor tell the nurse, hang a bag of D5W with normal saline, that's what that would be commonly referred to as. And that sometimes is hung by itself, which means it doesn't require any sort of compounding. It's just given by itself.

But certainly some of the products in here that do contain dextrose or just sodium chloride might be used in compounding other products in various ways. They might be used as a basis for the total parental nutrition products -- the compounded products I mentioned. They might be used as the diluent if you were going to reconstitute, say, an

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antibiotic, and put it into another solution to run an infusion over half an hour or an hour or something. You might reconstitute the antibiotic, draw it up into a syringe and direct -- and put it into a bag of normal saline, for example, depending on what the product is.

Q. And that process would be compounding, correct?

A. That process could be compounding.

Q. At the bottom of the second page of your email that we have marked as Exhibit 492, you suggest two approaches for resolving the issue being addressed by NAMFCU. That is the difference between AAC and AWP, correct?

A. Yes.

Q. Okay. And the first of the suggestions you have is for the state Medicaid agencies to be allowed to work out their own solution by either increasing the discounts off of AWP, adjusting the dispensing fee, establishing MACs or some other method, correct?

A. Correct.

UNITED STATES DISTRICT

FOR THE DISTRICT OF MASSACHUSETTS

IN RE: PHARMACEUTICAL	)	MDL NO. 1456
INDUSTRY AVERAGE WHOLESALE	)	CIVIL ACTION
PRICE LITIGATION	)	01-CV-12257-PBS
THIS DOCUMENT RELATES TO	)	
U.S. ex rel. Ven-a-Care of	)	
of the Florida Keys, Inc.	)	
v.	)	No.06-CV-11337-PBS
ABBOTT LABORATORIES, INC.,	)	

(cross captions appear on following pages)

Deposition of HARRY LEO SULLIVAN

Volume I

Nashville, Tennessee

Tuesday, March 12, 2008

9:05 a.m.

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things like saline or be it for, you know, sterile irrigation or injection or as a hydration solution or as an add mixture or whatever component to -- whatever service was being delivered in home health, we wanted that to come through the pharmacy program as well and be MACed because those products typically were very cheap. And --
BY MR. TORBORG:
Q. Were you --
A. And in a, in a, you know, home health agency is not doing anything slick or illegal by billing whatever their usual and customary charge is to Medicaid. But those -- if you're care -- if you're not careful and people are not cognizant of the costs of those drugs, you might dramatically over-pay.
Q. And when you say very cheap, do you mean there are large discounts off of AWP?
A. Well, again from my point of view, look at the net acquisition cost, most -- a lot of those things were multi-source items available

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from multiple manufacturers. And I didn't care which manufacturer they used, but I wasn't going to pay more than X.
Q. And how would you determine X?
A. Again, similar to what we were talking about earlier with, like solid oral dosage forms that become available generically. Find out what the cost is.
And, and, and, and in those environments, you know, you might talk to some other different types of providers some people in the home infusion or the home health agency business, and you just say, you know, I'm thinking about putting a MAC on this and this, what do you think? And get, get some kind of feedback.
Q. Just show you another document that we've marked previously. I don't want to ask you a whole lot of questions on it. Justice Exhibit 84.
MR. DRAYCOTT: Pardon me?
MR. TORBORG: 84, in the binders.

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BY MR. TORBORG:
Q. Take this one back.
For the record, this is a cover letter dated August 13th, 1996, from June Gibbs Brown to Bruce Fladdock, attaches an OIG report titled Review of pharmacy acquisition costs for drugs reimbursed under the Medicaid prescription drug program at the Florida Agency for Health Care Administration.
And then it attaches some comments that Florida provided to the report, which is -- the questions I'm going to be asking you about, Mr. Sullivan, is the last two pages of the document. And I'll ask you some questions in a bit --
A. The last two pages of the OIG document?
Q. Yeah, the last two pages of the exhibit.
A. Okay.
Q. Yeah, the very last two pages.
A. All right.
Q. There is a letter here from Douglas Cook, appears to be the Director of the State of

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Florida for Health Care Administration.
A. Um-hum.
Q. Did you ever meet Mr. Cook?
A. No, I have not.
Q. Did you ever meet Mr. Jerry Wells?
A. Oh, absolutely.
Q. And have you talked to him a number of times? It sounds like you're pretty familiar with him.
A. Yes.
Q. And how is that?
A. He was, he was one of the deans of the Medicaid pharmacy administrators, very smart, very sharp, in a very dynamic, difficult-to-manage state from a Medicaid standpoint. Very outspoken, very knowledgeable. Somebody that you, you'd bounce things off of. Maybe not always agree, but bounce things off of.
Q. In the second page of Mr. Cook's letter, first paragraph, I'll read it into the record, if you would follow along, Mr. Cook wrote, In general products and associated

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intravenous fluids also continue to be problematic. Manufacturers offer contracts to most vendors providing very favorable pricing and terms, but manufacturers continue to market small quantities of those, of these through conventional sources and report single-unit pricing through the national data sources. Any assistance your office might offer in standardizing pricing in this market would be beneficial.

Do you see that?

A. Yes.

Q. Do you have an understanding of what Mr. Cook is saying?

A. He's wanting the federal government to, to MAC these things instead of take the heat for MACing them himself.

Q. Okay.

A. I don't mean to -- that's what it appears to me. I don't mean to call him chicken, but -- and it's not necessarily a bad approach to take. It's easier, if you're -- for example, if

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your home health agencies in your state, you know, are very politically connected, have a strong lobby, and will go to war over you implementing this policy, then having the federal government do it for you and you being able to say, I'm going to lose state match if I don't comply, really shifts a lot of the fire to another source.

MR. DRAYCOTT: Dave, I didn't want to interrupt the witness, but I need to interpose an objection at the end of your question.

MR. TORBORG: Okay.

A. And I'm just -- you know, I'm just guessing, the way this is written. I don't know what he was -- his motivation was.

BY MR. TORBORG:

Q. And he talks about reporting single-unit pricing.

Do you understand what he means by that?

A. Yes.

Q. What's he mean by that?

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MR. DRAYCOTT: Objection.

BY MR. TORBORG:

Q. What's your understanding of what he means by that?

A. Well, it could be -- well, again I think he's leaving it up to the, to the Feds to determine whether -- and there is -- this has always been a, a point of confusion in claims processing systems, does a, you know, a 500 ML bottle of normal saline solution count as $10 divided by one or $10 divided by 500? A reconstitutable antibiotic like Rocephin counts as one. What does the dilutant that you put in there, the 200 cc's or whatever it is that you put in there to dilute that powdered antibiotic, is it one or, or 20? And do -- so does the provider bill me 20 units or one unit? If I set up in my system divided by 500, then they bill me one unit, because they're billing by the bottle, they're shorted, I'm to the good. In the office it could happen. I could get, if I set the units up wrong and they bill 500 and I've got it priced

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as one, then they'll be paying 500 times that.

So I think this, this gets at not only the question of pricing and a MAC, is what he's asking for, but also gets it and you tell me what the units should be.

Q. Do you know what he is talking about when he talks about manufacturers reporting single-unit pricing?

MR. DRAYCOTT: Objection.

You can answer.

A. Well, I, I just -- no, I don't know what he's saying. I could guess but I don't know what he means by that.

Again I think he's asking for clarity on units and MAC and he's wanting somebody else to do it for him.

BY MR. TORBORG:

Q. Were you aware when you were the director of pharmacy services of Tennessee that manufacturers were offering very favorable pricing for injectable products in IV fluids?

MR. DRAYCOTT: Objection.

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A. Ah, yes.
MR. TORBORG: I would like to mark this as the next exhibit.
(Exhibit Abbott 575 marked.)
MR. DRAYCOTT: What's the number, please?
THE REPORTER: 575.
BY MR. TORBORG:
Q. For the record, what I have marked as Abbott Exhibit 575 bears Bates Nos. ACMDL 77735 through 36.
Mr. Sullivan, I'm sure you're probably not aware of this document, but I wanted to ask you some questions about it, nonetheless.
Let me verify that you are not familiar with this document, relates to Kansas?
A. That's correct.
Q. Okay. There is a contact person that's listed there on this document, Gene Stevens. Do you know who that is? Have you had contact with him?
A. Yes.

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Q. Okay. Is he a pharmacy administrator for the State of Kansas?
A. Yes.
Q. And have you met Joyce Sugrue? Does that name sounds familiar?
A. No.
Q. S-U-G-R-U-E?
A. No, I don't recognize that name.
Q. Okay. Under -- there, the very last part of the page, there is a final policy where it states, Effective of dates of service 1/1/95, all sterile irrigation solutions and all large volume parenteral and small volume parenteral fluid replacement in vehicles for intravenous drug administration which are billed as pharmacy claims will be reimbursed at AWP less 50 percent.
A. Right.
Q. Paren, inhalation solutions are not included in this reimbursement change, end paren. And then there is -- the next page -- let me ask you if you understand what they're saying there. Does that make sense to you?

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A. Yes. Yes.
Q. The next page, rationale for the change, it states, Discounts from the referenced pharmaceutical pricing schedule, known as average wholesale price, vary by product class.
Were you aware of that?
A. Yes.
Q. Okay. And when they use the word product class, do you know what they're talking about there?
A. Drug class, I assume.
Q. What is that?
A. Well, not necessarily drug --
Q. What different drug classes are there?
A. No, I, I -- well, it's a very broad statement. It, it could be -- it then talks about IV vehicles and irrigation solutions, so I would assume that the first sentence is talking about those type of products rather than specific drugs.
Q. Then it goes on to say, Generally intravenous vehicles and irrigation solutions are

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available at much greater discounts than are other pharmaceuticals. This is one of the three methods used to reduce expenditures in the pharmacy program.
Were you aware that generally intravenous solutions and irrigation solutions were available at much greater discounts than other drugs?
A. Um, generally, yes. Because -- but it would depend on are you a, a hospital? A doctor's office? An outpatient surgery clinic? A home health company? Or a retail pharmacy.
Q. Those different customers pay different amounts?
A. Or a nursing home, even.
Yes.
Q. And could the amounts paid be, in your experience, radically different?
MR. DRAYCOTT: Objection.
A. Yes.
BY MR. TORBORG:
Q. And when you had situations like that,

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when -- let me step back.
All of those type of companies could file claims to the Tennessee Medicaid program; right?
A. Yeah, there's an enrollment process for providers, but pretty much open to anybody who, who wanted to enroll.
Q. And all of those companies could potentially file claims for reimbursement for drugs; is that right?
A. You talking about providers now?
Q. Providers.
A. Yes.
Q. And some of those providers paid more than other providers for drugs; right?
A. Yes.
Q. And sometimes, as we talked about, --
A. However, let me -- I did mention hospital, so, yeah.
Q. Okay. Let's take hospitals out of the equation.
A. Yeah, let's take them out. There's a

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per diem.
Q. But the others ones you mentioned.
A. Yeah.
Q. They would all file payments -- file claims for payment; correct? For pharmacy claims.
A. Yes. But there may be -- yes. But there may be situations where, you know, the home health agency may subcontract with a pharmacy who is, so -- yeah, but eventually, yes.
Q. And they could pay different prices for drugs.
A. Yes.
Q. How would you deal with that from a policy perspective in trying to decide how much to pay?
A. Well, you know, we took a pretty hard line, and, and again tried to be fair when you set a MAC, and take into account all the different provider -- the ripple effects of setting that MAC.
Um, but I'm sure -- and I'm sure that,

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you know, dealing with a Medicaid program, this is not a, not a new concept, but I'm sure in a lot of instances those sorts of products are eaten by the provider, if -- or the difference between the MAC and their cost is eaten. And they have to make a determination if it's worth it to, to provide that service.
Q. Sometimes the pharmacy --
A. And typically, typically.
Q. And sometimes they don't.
A. You could have a laundry list of things you're billing for.
Q. Um-hum.
A. You're just not billing for one sterile solution or little IV solu -- there is drugs it in, there's services in it, there is supplies, there's bandages, and, you know, all that.
And, you know, you may just figure a little hit on the difference between the MAC and whatever you're -- you pay. But again, by and large the MAC's set, so it's not a disincentive.
Q. You would look at the big picture.

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A. Try to.
Q. And you referred earlier to the National Pharmaceutical Council reports?
A. Yes.
Q. And those, among other things, would set forth the state's payment methodology for drugs.
A. They would -- yeah, they would report what those --
Q. What the state's told them --
A. Yes.
Q. -- it was?
A. Yes.
Q. And do you know if a methodology specific to IV drugs such as we see in Kansas would be put in there?
A. I don't know. I don't know if that was part of the survey or not. I --
Q. But if it was in there, everyone who reviewed the NPC reports could see what Kansas --
A. Sure.
Q. -- had done?

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A. Sure.
MR. TORBORG: Why don't we take a break.
VIDEOGRAPHER: Going off record. End of tape 2. Time now is 11:31.
(Recess.)
(Exhibit Abbott 576 marked.)
VIDEOGRAPHER: Back on record. Beginning of Tape 3. Time now is 11:49.
BY MR. TORBORG:
Q. Welcome back, Mr. Sullivan.
A. Yeah.
Q. I have marked and handed you as Abbott Exhibit 576 a document that bears the Bates Nos. VAC-MDL 75533 through 66.
For the record, and so that you know, this is a document that was produced by the relator in this case, a company called Ven-A-Care of the Florida Keys, Inc., and particularly these were documents that were looks like contained in a folder titled Tennessee. And as you were the director of pharmacy services at Tennessee, I

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thought I might ask you about some documents contained therein.
A. Okay.
Q. In particular I would like to start with the Bates page ending 539. This is an October 24th, 1994 letter from Zachary Bentley to Leo Sullivan regarding state policy and methodology for reimbursement of intravenous solutions and injectable drugs. Do you see that?
A. Yes, sir.
Q. If you would take a look at that document. Let me know if you recall it and then I'll have some questions for you about it.
A. Okay.
Okay.
Q. Mr. Sullivan, do you recall this, this particular page?
A. I really don't.
Q. Do you recall ever having any correspondence or communications with Zachary Bentley or anyone else that you understood to be affiliated with Ven-A-Care of the Florida Keys?

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A. I honestly do not remember.
Q. Have you ever heard of the company Ven-A-Care?
A. No, I really -- the logo looks familiar, but I don't know by what context I would know them.
Q. Do you recall that some company was working on a project, a continuing education project --
A. No.
Q. -- concerning these kind of drugs?
A. No.
You, you have to know that during the course of a week you'll get, in a position like that, you'll get all kinds of requests for surveys and stuff like this.
Q. If we go to the page preceding this page, page ending 538, there is a document titled Response to National State Medicaid Reimbursement Survey. Contact person is -- that's you; right?
A. Yes.
Q. And then it appears as though you gave

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him some information relating to Tennessee's reimbursement for IV drug reimbursement and TPN reimbursement. Do you see that?
A. Yes.
Q. And in particular IV reimbursement was AWP minus 8 percent plus a $3.91 dispensing fee per ingredient.
And was that the standard, from your recollection, was that the standard reimbursement rate that Tennessee used for drugs at that time?
A. No.
Oh, this, this information is not accurate at all.
Based on the date 11/29/94 we're almost a year into TennCare. I wasn't paying for any, any of these products. The MCOs, through their PBMs, or however they set up reimbursement, for paying for this. So somebody, sounded like somebody just got an old NPC book and wrote this down. I don't remember talking to them. I may have. But this is not accurate information.
The state didn't have a policy for IV

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drug reimbursement during this time period. We paid capitated fees to MCOs.
Q. Do you believe it's possible that you never even had a discussion with anyone else from Ven-A-Care?
A. I -- you know, you have so many calls and so many -- I mean all day long, every day, I, I'm not going to say that I absolutely did not talk to these people. It looks like, too, on number 3 it says price negotiated with various provider of TennCare system. Somebody's writing something down here that didn't, didn't even understand TennCare. I mean these prices -- whatever, whatever reimbursement there was in this time period, 11/29/94, was strictly between the MCO and their provider network and it would vary from MCO to MCO.
I mean at this point in time there were 12 different MCOs in TennCare. Nobody could fill out this form for TennCare. There would be 12 forms, and it wouldn't be me as the contact personal, it would be the medical director of the

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MCO or the pharmacy director of that MCO or the PBM.
Q. Did the MCOs in TennCare, did they have different methodologies for reimburse -- for paying for drugs, or did they all use the same one?
A. Right out of the gate in January, I think they all pretty much piggybacked what we had in place at December 31, 1993, but by midyear -- and the, and the reason that is is because the waiver wasn't even approved until November 22nd.
Q. Of '94?
A. Of '93.
Q. '93?
A. And we went live January 1st, '94, you know, a month and a half later.
What we had done prior to whatever approval, the whole 1993, was identify potential MCOs, give them contracts that outlined their responsibilities and even actuarial information on capitation rates, but we couldn't fully execute the contracts with those 12 MCOs until

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HFCA approved the waiver.
The -- we could negotiate, we could have it all set and ready to go when HFCA did give that approval, consequently, then, the MCOs were unable to fully execute provider contracts with physicians, hospitals or anybody else, until they had a contract with TennCare.
So it was a cascade of events that started on 11/22/93, implement and go live a month and a half later with 1.4 million lives. Just ridiculous implementation schedule.
But it, but it happened that way. So what happened on day one with the pharmacy program was just, just fill claims. Just pay claims. I mean pharmacists, the whole first couple of months of TennCare, were filling prescriptions on faith, not even know who to submit the claim to or if and when or what the amount of reimbursement would be.
By mid '94 and on into early '95, we eventually evolved into a situation where there were still at that time maybe 12 MCOs, with six

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different PBMs handling those, and then later on it evolved to, you know, some of these MCOs went bust or quit or whatever, and you had eight, maybe eight MCOs dealing with two or three PBMs and 95 percent of the enrollment was actually under one PBM by the way the enrollment fell with those eight MCOs, so it -- this is somebody, somebody fudged this to just get a report done is what it looks like to me.
Q. Under the state policy for DPM reimbursement AWP plus 33 percent, do you recall if that was a policy that Tennessee had before TennCare was implemented?
A. I don't know where they would have gotten that. TPM reimbursement was MACed. At some point in time it became MACed, TPM Solutions did. But it certainly was not AWP plus 33 percent. You know, cost plus 33 is closer to it.
Q. Do you recall ever discussing at the meetings you had with other state Medicaid representatives, pharmacy representatives, the subject of any lawsuit relating to average

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Q. Mr. Sullivan, I have handed you what we have marked as Abbott Exhibit 577. It has the Bates Nos. HHC 002-0423 through 30.
If you would take a look at that just to see if that's a publication that you're aware of.
A. Yes, it is. I got these.
Q. Okay. Can you tell, can you tell us what this, what this document is.
A. Um, just -- I think -- well, let's see. Appears, I don't know, every couple of months, I guess. Just news. There were some of my peers on an advisory board who would send in various information, updates or particular issues that are going on in different states, Medicaid pharmacy programs. It was Medicaid specific.
Q. And do you know who all received these pharmacy or Medicaid pharmacy --
A. I think all the --
MR. DRAYCOTT: Objection.
A. -- pharmacies directors.
BY MR. TORBORG:

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Q. And what, what makes you think that?
A. Because that's -- I believe that was pretty much the -- one of the audiences targeted with it.
Q. And this particular bulletin is dated January-February of 1990.
A. Um-hum.
Q. Correct?
A. Yes.
Q. And that's when you would have been the director of pharmacy services you would have been director of pharmacy services of Tennessee at that time.
A. Yes.
Q. And this has an article titled Revisiting Medicaid reimbursement for home IV drug therapy. Do you see that?
A. Yes.
Q. And in particular I have a few questions for you on this.
A. Okay.
Q. The first column, first page, the

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bulletin notes, reimbursing -- well, let me, let me back up.
Do you know who wrote these articles, generally speaking?
A. No, I didn't -- there is editor on here. I don't know her and I -- I know -- I certainly knew or got to know, after this time period, most of these people on the advisory panel. They're all Medicaid pharmacists.
Q. On page 454.
A. On page 2, yeah.
Q. Do you have any idea where the editor, listed here as Karen Nardi, how she obtained her information for articles of this magazine?
A. I, I assume -- no, I don't know. I would assume she interviewed folks.
Q. Did you -- were you ever interviewed for this publication?
A. I might have been.
I -- certainly not at this time period.
I had just started work for the state at this time, but I might have been, in

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subsequent issues.
Q. Here, first column, first page, it says, Reimbursing adequately and efficiently for home IV drug therapy has been a continuing problem for many Medicaid pharmacy administrators. Do you see that?
A. Um-hum, yes.
Q. Was this a problem that you were, that you were confronting, or not?
A. Yeah, I think, because there's so many inlets to the system from the provider side that you have to be very vigilant of, you know, how many claims get in the system. And whether or not they're paid or rerouted or denied or how they're handled.
Q. Then later on in that paragraph it states, a number of states are concerned that their current reimbursement methodology for home IV therapy is inadequate and are trying to develop improved systems which will permit them to pay providers more quickly while avoiding overpayment. Was that -- did you ever have

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wholesale price.
A. The only thing I remember vaguely is, and it didn't really -- it didn't really impact me, and I don't recall if Tennessee was a part of it, but it was some suit that did involve I believe Abbott and maybe some other folks, maybe TAPP, but I'm not sure about that, where there was an allegation, and I don't know, ultimately the -- you know, it may have been settled in some settlement, and I don't know about blame or guilt or any of that, but my memory is that it involved selling injectable type drugs or products to physicians to be administered in the physician's office.
And I guess the allegation was that the AWP was either inflated or well above the actual cost to the physician for the product.
And personnel for the manufacturer were instructing physicians on, you know, if you buy my product, we sell way below AWP, Medicare or Medicaid or whoever is reimbursing based on hundred percent of AWP, or whatever it was, and

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you'll make a killing using my drug, and it was --
Q. Have you heard the term marketing to spread?
A. Yes.
Q. Is that what you're talking about?
A. Yes.
Q. Okay. I'm sorry. I think I may have cut you off.
A. But I don't know if the, but I don't know if the allegations were just that the price had been lowered so much or if the AWP had been finagled or -- with the publishers of AWP or both, I don't know what the outcome was or the real allegations. I was just aware of some -- and it, and it had to do with physician's offices is my recollection.
Q. Did it relate to Lupron? Does that ring a bell?
A. That certainly was one. And also injectable other solutions, I think, as well. But I don't, I don't -- like I said, I never got

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involved in that case. I just remember hearing about it.
Q. When did you first start hearing about it?
A. Oh, gosh, I don't know. Sometime in the Nine -- mid Nineties, I would guess. I'm not sure.
Q. Was it something that you recall being discussed at the national symposium --
A. No.
Q. -- meetings?
A. No. Again this is, this had to do with physician offices or --
Q. Where did you learn about it?
A. Through -- I, I would -- you know, trade journals, you know, news. I had no direct involvement in it. The industry. I remember just rumblings through the industry that -- it seems to me there was a significant settlement. I don't, I don't know what it was.
Q. Did you -- what types of news, periodicals, did you review in your work as the

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director of pharmacy services?
A. Um, you know, everything from clinical journals to trade, trade journals.
Q. Do you recall any particular ones?
A. Oh, gosh.
You know, managed care pharmacy things. Pharmacy, I'm sorry, drug topics, you know, stuff from the APHA. Regular news, CBS, NBC, CB -- or ABC.
Q. Did you -- did your office have a subscription to any of these?
A. Yes. Probably -- well, all the pharmacy journals, I think most of those -- well, I'll say all the ones that are free. Most of them were free. But all the ones that are free, we -- I don't think I ever paid anything, could get the state to pay for anything, but --
Q. Okay.
MR. TORBORG: Going to mark this as another exhibit.
(Exhibit Abbott 577 marked.)
BY MR. TORBORG:

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concerns on whether or not the payment for these kind of therapies was, was adequate?
A. Well, my opinion, particularly in the, in the home health arena, was -- and during this specific time period, the growth in Tennessee was such of those type of providers that it wouldn't -- that wouldn't -- not lead you to believe that the reimbursement for Medicaid was inadequate.
When people are hollering and screaming or you have trouble getting providers to take care of your patients is when that was more likely a concern.
Q. Well, do you know when the home infusion business really started taking off?
A. Well, it certainly took off in the early Nineties. And I can't remember -- and Tennessee was a little bit different because we very purposely avoided expansion of home community based services under the Medicaid program because the vast majority of the patients who would receive those services were dual eligibles, which meant they had Medicaid and

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Medicare. And Medicare home health was, was truly exploding. We had hundreds of providers in Tennessee of home health services. I dare say there's, you know, maybe 20 now. Because there was, there was indeed a bonanza on the Medicare side in Tennessee. Other states didn't face it quite as -- if they had chosen to expand or had very aggressive home community-based services through Medicaid, might have had a little bit different policy issues. We purely shifted to Medicare, cost shifted to Medicare, with the duals. And so it wasn't maybe not as, as intense on a Medicaid issue in Tennessee as it might be elsewhere is what I'm saying.
Q. The page starting with -- at 425 and then going over to 426, there is a discussion of what some states are doing in the home IV reimbursement area, Minnesota indicates compounding or a dispensing fee of $8 for IV drugs, and then Washington indicates that they're paying a compounding amount, Ohio as well.
Do you have an understanding of what

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they're talking about when they talk about a compounding fee?
A. Yes.
Q. And what, what is that?
A. Well, certain, be it -- I mean you can compound IV drugs if you have the right equipment and filters and hoods to keep it, make it a sterile product.
And you can compound drugs for inhalation. If you have, again, the right equipment, similar to what would be in a hospital, to, to handle sterile products.
And you take the raw ingredient and mimic whatever, generally, the brand name or the innovator product was.
Q. And do you know in Tennessee, either before TennCare or after TennCare was paying a compounding fee for IV? Do you know if that was something that was being paid?
A. Ah, no. But there's, there's ways to pay it without, without having a separate -- you know, I noticed on here that one form is for

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payment, one form is for reimbursement of supplies, one form is for -- you know, they're, they're making a variety to submit multiple forms. And I wouldn't -- I can't tell you a specific product or specific time period, but one of my strategies was in issues like this, where compounding was involved, I didn't want to go down the road, at least in the early Nineties, of getting into paying for compounded prescriptions, because that can -- that could range from a sterile product all the way down to an ointment, okay?
And, and our claims reimbursement system hadn't evolved to the current NCPDP sophistication of today. So it was very hard to put in a, a set compounding fee for what, what products?
One may take a minute to make, one may take an hour and a half.
So getting back to, to the MAC issue, some, sometimes for certain products in this arena, you would take that into account for the

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MAC.
For example, I might say, I'm not paying for the tape that you use to hold the IV needle into place. I'm not paying for the IV needle or the tube set. I'm not going to -- I don't want bills for that. I know you've got to do it to administer this drug. So we're going to add on the cost of this drug X, because I know this, this and this always goes with it, and I know there is a fixed cost for that, but I don't want five bills. I want 10 different places. Bill me for the drug. And I'll make sure that the -- whatever the MAC is incorporates all your other costs. And you have to talk with providers and know what that is. I mean, you know.
Q. So, in short, you would use the payment for the drug itself to cross-subsidize other things that might need to be paid to fairly --
A. And that would include compounding.
Q. And it may include nursing services that were not included, things of that nature?
A. (Nodding yes.)

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Q. Did anyone in the federal government ever tell you that you were not allowed to do that?
A. No.
Q. And if they had told you that, what would you have said?
A. That I wasn't allowed to pay for compounding or --
Q. That you weren't allowed to use the payment for the drug to cross-subsidize those other services or supplies.
A. If they had told me I couldn't do it, what would I do?
Q. Yes.
A. I would have had to have found another way to, to handle the billing.
Q. But they never told you that.
A. No.
Q. Do you know if other states were doing -- were adopting similar type strategies to run the programs?
A. No, I don't -- I mean it may be

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addressed in this letter. I don't know. It seems to talk about different states, but I'm sure there were varying levels of complexity in the billing process, and what was and wasn't billable and what was and wasn't included, but I don't know it and I didn't discuss it with folks.
Q. Have you heard the term cross-subsidy or cross-subsidization in the context of pharmacy reimbursement?
A. No, not -- no, I haven't.
Q. I'm going to show you another, another -- going to mark that as another exhibit.
MR. TORBORG: I think this is 578.
(Exhibit Abbott 578 marked.)
BY MR. TORBORG:
Q. For the record, what we have marked as Exhibit 578 bears the Bates numbers HHC 002-0400 through 407. It's another Medicaid pharmacy bulletin. This one dated January-February of 1988.
Mr. Sullivan, if I could ask you to go to Bates page ending in 402. In particular the

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discussion on the first full paragraph about Montana Medicaid. Do you see that?
A. Yes.
Q. Where it says, Similarly, Montana Medicaid compensates for the additional time and expense of dispensing compounded drugs by allowing the provider's usual and customary charge up to 2.5 times the cost of ingredients, paren, reimbursement for other outpatient drugs is a lower of AWP minus 10 percent, or the cost of the drug, end paren. Do you see that?
A. Yes.
Q. Is that the, the type of thing that Tennessee was doing?
A. It's a different approach to -- yeah. Make -- paying the provider for the, for the compounding without -- and setting a limit on what I will pay up to two and a half percent. It's just a different, different twist.
Q. Does it -- does this refresh your recollection about any other types of approaches like this that other states were using?

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-- there is a cost to dispense. It's kind of like AWP, it's inflated. Because there's so many factors come into the light switch, the -- whether or not your little drugstore and you offer health insurance to your six employees. Heck, if you offer health insurance to six employees, it's going to be very expensive. And that's figured into the cost to dispense. So it's very variable.

Q. Let me ask you about one more document before we break for lunch, if that's all right.

A. Sure.

Q. Do one more?

A. I'm good.

Q. Let me ask you about Exhibit 21 in this binder.

For the record, this is a document dated in 2002, August 2002, titled Determination of the Cost of Dispensing Pharmaceutical Prescriptions for the Texas Vendor Drug Program. It's prepared for the Texas Health and Human Services Commission.

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In particular I'd like to ask you to go to the third page of this exhibit under Summary of Findings.

The last bullet there states, Average dispensing costs at certain pharmacy specialties was observed to be higher than dispensing at, quote, typical, end quote, retail pharmacies. In particular, we noted higher dispensing costs associated with pharmacies that provide services related to the dispensing of intravenous, home infusion and compound prescriptions.

Do you see that?

A. Yes.

Q. Did you become aware, Mr. Sullivan, that intravenous, home infusion and compounded -- I'm sorry. Strike that.

Did you become aware that pharmacies providing services relating to intravenous, home infusion and compounded prescriptions had a higher cost to dispense?

A. Yes. I wouldn't say become aware. I mean it's -- a pharmacist has to do compounding,

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pretty much hands on, and the normal rate paid a pharmacist drives up that cost when -- as opposed to a technician filling a prescription for some tablets.

Q. If I could ask you to go to page 43 of this study. The third full paragraph starts with, Although the analysis. Do you see that?

A. Yes.

Q. The last sentence of that paragraph states, It is therefore possible that some pharmacies could very well have dispensing costs in excess of $40 per prescription. And then the next paragraph states, Under current policies the Health and Human Services Commission reimburses for intravenous prescriptions and a dispensing fee plus ingredient reimbursement formula for traditional retail prescriptions.

Although dispensing costs at intravenous pharmacies appears to be in excess of the current base dispensing fee of $5.27, this reimbursement methodology has been accepted by these pharmacies likely due to the inventory

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management add-on to expense dispensing fee, paren, which can be significant on the expensive drugs traditionally dispensed in intravenous forms, end paren, and the margin on ingredient reimbursement, which has allowed pharmacies to offset a shortfall from a base dispensing fee.

Do you see that?

A. Yes.

Q. Do you have an understanding of what they're talking about there?

A. Yes.

Q. And did you have any experience talking with providers of intravenous therapy, home infusion therapy, that they were accepting an insufficient dispensing fee because of the margin allowed on the ingredient reimbursement?

A. I wouldn't say specifically in those terms, but I, but I certainly had discussions with these types of providers on how much I've got in it and how much you're paying me.

And not specific numbers, but that -- and disparities, too, I think were one of the

UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF MASSACHUSETTS

IN RE: PHARMACEUTICAL
INDUSTRY AVERAGE
WHOLESALE PRICE LITIGATION

MDL NO. 1456
NO. 01-CV-12257-PBS
JUDGE PATTI SARIS
MAG. MARIANNE BOWLER

THIS DOCUMENT RELATES
TO U.S. EX REL.
VEN-A-CARE OF THE FLORIDA
KEYS, INC. V. ABBOTT
LABORATORIES, INC., ET AL.,
NO. 06-CV-11337-PBS

VIDEOTAPED DEPOSITION OF MARY JULIA TERREBONNE, 6080 ESPLANADE AVENUE, BATON ROUGE, LOUISIANA 70806, TAKEN IN THE OFFICES OF LOUISIANA DEPARTMENT OF HEALTH & HOSPITALS, BIENVILLE BUILDING, 628 N. FOURTH STREET, BATON ROUGE, LOUISIANA 70806, ON THE 31ST DAY OF MARCH, 2008.

claims data, that kind of thing?
A. Right.
Q. How about if you had an e-mail from a provider or a provider had a question concerning payment rates in, say, the mid-1990s. Is that the kind of thing that you would keep?
A. I would probably keep it if it were related to some type of state plan that we may be submitting, but just to keep it, if it doesn't pertain to anything, I wouldn't keep it.
Q. Do you know if the department has a formal document retention policy?
A. I do not.
Q. Do you have a general understanding of what it is that the United States government, as the plaintiff in this action, alleges that Abbott did wrong?
A. I do not.
Q. Is it your understanding that the case relates to the subject of average wholesale price?
MR. FAUCI: Object to the form.
THE WITNESS: It is my understanding.

BY MR. TORBORG
Q. How did you obtain that understanding?
A. I think I saw it on the document that you sent.
Q. Okay. Do you have an understanding of the nature of the damages that the United States is seeking against Abbott?
A. I do not.
Q. And do you have an understanding of the types of drug products that are at issue in the case?
A. I do not.
Q. To your left, Ms. Terrebonne, are a couple of boxes that have documents. I'm not going to ask you about all of those. Those are copies of exhibits that we have used with people who came before you. From time to time, I would ask you to take out Exhibit X. There are tabs in those orange binders that indicate where you would find such exhibits.
The first one I would like to go to, it should be in the first volume at tab 19. If you

would be so kind as to take that out. I have copies for you and counsel.
Okay. It looks like you have successfully managed to get Abbott Exhibit 19. That puts you ahead of others we have done before.
Abbott Exhibit 19 is a copy of the United States' complaint against Abbott Labs in this case. I take it, given your responses so far, you have never seen this document. Would that be fair to say?
A. Yes. That's correct.
Q. If I could ask you to go to page 10 of the complaint, in particular, paragraph 31, there is a listing of drugs and their corresponding NDC numbers that are at issue in the case, that is at the bottom of page 10, carrying over to page 11. Do you see that?
A. Yes.
Q. And you are familiar with what a National Drug Code is, correct?
A. Yes.
Q. If we look through the listing of the

drugs, I think you will see that the drug products fall into a few categories, including sodium chloride injection, sodium chloride irrigation, sterile water injection, sterile water irrigation, vancomycin, then a number of dextrose solutions. Do you see that?
A. Yes.
Q. Are you familiar with these drug products?
A. Yes.
Q. Are you familiar with the term "large volume parenterals"? Am I pronouncing that right?
A. Yes.
Large volume parenterals, no.
Q. How about parenterals?
A. I'm familiar with that.
Q. What are those?
A. Those are used IV.
Q. Have you come across, in your work, these drugs?
A. Yes.
Q. And do you know how they are dispensed to

Medicaid beneficiaries?
A. How they are dispensed? Through a pharmacy.
Q. But these are not the type of -- these are not pills, correct?
A. Correct.
Q. They appear to be drugs that are supplied either through home IV or through some sort of infusion?
A. Correct.
Q. Do you have an understanding of the types of pharmacies in Louisiana who would have dispensed these drugs to Medicaid beneficiaries?
A. Probably IV pharmacies.
Q. Any other types?
A. Well, it is not your normal retail pharmacy, so --
Q. Would you agree that dispensing these types of drugs to Medicaid beneficiaries is a more cost-intensive procedure than pills?
MR. FAUCI: Objection, form.
THE WITNESS: I know there are -- it is

different than dispensing pills, I am aware of that.
BY MR. TORBORG
Q. How is it different?
A. These pharmacies have IV hoods and they have certain packing that they have to adhere to, and the sterility and those kinds of things.
Q. Is it your understanding that it typically costs more for pharmacies to dispense these drugs to Medicaid beneficiaries, than say, a pill?
MR. FAUCI: Objection, form.
THE WITNESS: I'm not familiar with the cost involved, I just know it is a different set of circumstances.
BY MR. TORBORG
Q. I would like to back up a little bit and walk through your educational background and work history briefly.
Did you attend college?
A. I did.
Q. And where did you attend college?

A. Nicholls State University and Northeast Louisiana University in Monroe.
Q. And did you receive a degree from either of those institutions?
A. From Northeast.
Q. What was your degree in?
A. Pharmacy.
Q. I think I have seen somewhere that you are a registered pharmacist. Is that right?
A. Correct.
Q. What does it take to become a registered pharmacist in the State of Louisiana?
A. You have to have your degree in pharmacy, and you have to pass your board and get your board -- your certificate renewed every year.
Q. Are you still an active registered pharmacist?
A. I am.
Q. What types of continuing education courses does one have to take as a registered pharmacist in Louisiana, if any?
A. You have to have 15 hours.

Q. Have you taken any courses on the subject of -- the broad subject of payment rates for pharmacies?
A. Not that I recall.
Q. Have the courses focused more on the medical side of pharmacy?
A. The clinical side.
Q. Clinical side?
A. (Witness nods head affirmatively.)
Q. And do you have any advanced degrees?
A. I do not.
Q. What year did you graduate from Northeastern University? I'm sorry, Nicholls -- give that one to me?
A. Nicholls is the pre-pharmacy, and Northeast is where I received my pharmacy degree in 1978.
Q. That's called Northeast University?
A. It is now called the University of Louisiana in Monroe.
Q. UL Monroe?
A. Uh-huh.

aware of other states who calculated their maximum allowable cost in this fashion?
A. I am not.
Q. Do you recall discussing Louisiana's method for establishing maximum allowable costs with other states?
A. Not that I recall.
Q. Were you aware that the Louisiana method for calculating maximum allowable cost limits was similar to the way which Medicare calculated its reimbursement for drugs using a median AWP?
MR. FAUCI: Object to the form.
THE WITNESS: I do not.
BY MR. TORBORG
Q. The last sentence of that paragraph that I was referring to states, "LMAC limits may be adjusted by Medicaid of Louisiana based on changes in availability and EAC of the drugs."
Do you see that?
A. Yes.
Q. What is meant by "changes in availability of drugs"?

A. Occasionally, providers would contact us and say they were not able to purchase the drugs at a price that would be reasonable for the LMAC limit. So we would call the wholesaler and ask them if it was available at that price, and they would tell us yes or no, and we would adjust it accordingly.
Q. Do you recall this happening where some generic -- manufacturers of generic products, these products would not be available, do you recall this happening?
A. Right.
Q. Do you recall any specific drugs this happened with?
A. I don't.
Q. Do you recall this issue ever arising with the drug vancomycin?
A. Not to my knowledge.
Q. Do you know what kind of drug vancomycin is?
A. I do.
Q. What is it?

A. An antibiotic.
Q. Do you believe there are issues with the availability of vancomycin from some manufacturers?
A. Not that I recall.
Q. May have happened, you just don't recall?
A. Right.
Q. You can't recall any particular drugs for which there was an availability issue. Is that fair to say?
A. Not by name. I don't recall. My staff may know, I may not know.
Q. Second paragraph under the LMAC section of the state plan notes that an LMAC cost listing would be distributed periodically and a provider could get one at least annually?
A. Yes.
Q. What type of form would that document be in?
A. It was a hard copy listing of the drugs that were payable under our program, and we listed the LMAC on the listing.
Q. And do you recall sending providers

copies of the LMAC?
A. Yes.
Q. Something they were particularly concerned about, right, from --
A. Yes.
Q. And what you were telling them in this document from the State of Louisiana was we will pay you this much in ingredient cost reimbursement for these drugs, correct?
A. We didn't tell them we'd pay them, we said these are the LMACs and the FULs for these drugs.
Q. And you expected them to rely on that information in deciding whether or not to participate in the program, correct?
MR. FAUCI: Objection, form.
THE WITNESS: I don't know that they relied on the drug prices listed on the information we sent to them. I think they used it for information.
BY MR. TORBORG
Q. Information for what purpose?
A. For determining whether they needed to

for generic drugs in the compendia, AWP prices, were a reliable indication of how much providers were paying for drugs, net of chargebacks, discounts and rebates?

MR. FAUCI: Objection, form.

THE WITNESS: I didn't know that because I didn't know what the chargebacks or the discounts were.

BY MR. TORBORG

Q. Did you think, for example, that you could just take off 20 percent from those prices and get to a number that would be the acquisition cost?

MR. FAUCI: Objection, form.

THE WITNESS: No.

BY MR. TORBORG

Q. And why is that?

A. Because I didn't know what the actual acquisition costs were.

Q. Did you have reason to believe that you could not just simply discount the AWP numbers by a certain percentage, say, 20 percent, and get to a

reliable actual acquisition cost?

MR. FAUCI: Objection, form.

THE WITNESS: What I have been familiar with is to conduct a survey so you would have that document to represent what the average discount was.

BY MR. TORBORG

Q. Why don't we take a look at Abbott Exhibit 1051, one of the exhibits we marked here today. It will be in that stack right in front of you. It is the survey of dispensing costs, Myers and Stauffer. There it is.

In particular, I will direct your attention to page 6. The last bullet before the section "General" states, "The discounts from AWP for multiple source drugs exhibited much greater variation but averaged 32.6 percent for drugs without full pricing and 69.6 percent for drugs with full pricing."

Do you see that?

A. Yes.

Q. Does that refresh your recollection at

all on whether you believed you could take a discount, a set discount, say, of 20 percent and get to a reliable actual acquisition cost for multi-source drugs?

MR. FAUCI: Objection, form.

THE WITNESS: On the average.

BY MR. TORBORG

Q. Just for individual drugs?

A. Well, what this is saying is the average discount is that. For individual drugs, I know it varies.

Q. And did you know that varied -- there was a wider variation for generic drugs?

A. Yes.

Q. And Myers and Stauffer wasn't telling you anything in 1999 that you didn't already know about that?

MR. FAUCI: Objection, form.

THE WITNESS: They documented it, yes.

BY MR. TORBORG

Q. But would you have known that before 1999?

MR. FAUCI: Objection, form.

THE WITNESS: Based on reports that we had received from the OIG and that kind of thing. I did not conduct any surveys.

BY MR. TORBORG

Q. Going back to Abbott Exhibit 84, this is the Florida report. The last page of the exhibit, second page of Mr. Cook's response, he states at the top of that page, first paragraph, "Injectable products and associated intravenous fluids also continue to be problematic. Manufacturers offer contracts to most vendors providing very favorable pricing, but manufacturers continue to market small quantities of these through conventional sources and report single unit pricing through the national data sources. Any assistance your office might offer in standardizing pricing in this market would be beneficial."

Do you see that?

A. Yes.

Q. Do you recall, Ms. Terrebonne, becoming aware that the discounts on intravenous fluids and

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injectable products tended to be large?
MR. FAUCI: Objection, form.
THE WITNESS: I do not recall.
BY MR. TORBORG
Q. Something you may have been aware of, but you just don't recall as you sit here today?
A. It is not something that distinctly I would recall, no.
Q. And do you have an understanding of what Mr. Cook is saying when he notes that "manufacturers continued to market small quantities of these" -- and he is referring to injectable products and associated intravenous fluids -- "through conventional sources and report single unit pricing for the national data sources."
A. I do not.
Q. Do you have an understanding of what single unit pricing means?
A. I do not. I would assume that is something that is broken down on a single unit rather than a bulk.
Q. If I could ask you to go next to Abbott

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Exhibit 575. Ms. Terrebonne, this is a document that was produced by Ven-A-Care from the Kansas Medicaid program, I believe.
If you will go to the last paragraph on the first page, under "Final Policy," do you see that?
A. Yes.
Q. They wrote: "Effective dates of service 1-1-95, all sterile irrigation solutions and all large volume parenteral and small volume parenteral fluid replacement vehicles for intravenous drug administration which are billed as pharmacy claims will be reimbursed at AWP less 50 percent (inhalation solutions are not included in this reimbursement change)."
Do you see that?
A. Yes.
Q. Did you become aware that Kansas had at some point changed or had a special reimbursement methodology for large and small volume parenterals?
A. No, I did not.
Q. Go to the next page, "The rationale for

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change: States discount from the referenced pharmaceutical pricing schedule shown as average wholesale price vary by product class."
Is that also something that you knew, Ms. Terrebonne, that discounts from AWP could vary by product class?
A. I would think that, yeah, AWPs could vary by product class.
Q. Is that something you knew about from 1991 through 2001?
A. In relation to this?
Q. Just generally speaking.
A. No. No. And I think our documents supported that one of the items that they could not purchase at the discount was immunosuppressant drugs. So there is variation there.
Q. And in this document, the author also noted, "Generally, intravenous vehicles and irrigation solutions are available at much greater discounts than are other pharmaceuticals."
Do you see that?
A. Yes.

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Q. Is that something you became aware of at some point in time from 1991 through 2001?
A. No.
Q. Do you recall having discussions with Ven-A-Care of the Florida Keys?
A. I did not have any discussions with Ven-A-Care.
Q. Did you have any communications via a fax or document with people from Ven-A-Care?
A. I do not recall.
Q. Does the name Zachary Bentley ring a bell?
A. No.
(Exhibit Abbott 1054 was marked.)
MR. TORBORG: For the record, what I have marked as Abbott Exhibit 1054 bears Bates No. VAC MDL 77742 through 63.
BY MR. TORBORG
Q. Ms. Terrebonne, for the record, these are some more materials produced by Ven-A-Care of the Florida Keys related to this case. In particular, this was a collection of documents produced in a

file titled "Louisiana."

I would ask you to take a look at that if you would.

Ms. Terrebonne, do any of these pages look familiar to you?

A. I see my name on it, but I don't recall.

Q. Look at Bates page ending 77759. Do you see that?

A. Yes.

Q. This is a -- appears to be, at least, a fax from M. J. Terrebonne to Zachary Bentley at Ven-A-Care dated January 30 of 1998. Do you see that?

A. Yes.

Q. Is that your handwriting?

A. Yes.

Q. So it appears you had sent a fax to Mr. Bentley. Is that fair to say?

A. Yes.

Q. Does that refresh your recollection at all regarding communications that you had with Ven-A-Care?

A. No.

Q. If you look at the next page there, it appears to be next to the -- this appears to list NDCs and then reimbursement. Do you see that?

A. Yes.

Q. Do you recall providing Mr. Bentley with information regarding how much the State of Louisiana reimbursed for ingredients for a set of drugs?

A. I do not.

Q. If we go to the next page there, it appears to be part of the same fax. Is that right?

A. Yes.

Q. Is that your handwriting?

A. Yes.

Q. And did you write, "Zachary, Louisiana Medicaid reimburses the lower of 1, usual and customary charge, or 2, AWP minus 10.5 percent, plus a fee (the maximum fee is $5.77). I have listed the AWP for the drugs," which you listed. Then you wrote -- is that what you wrote?

A. Yes.

Q. And then you wrote, "I would appreciate," can you read that to me and into the record?

A. "If you could send me the information on the definition which exempts IV pharmacies from retail class of trade. Also, your findings of the states' analyses compared to the average acquisition price. Thanks."

Q. Do you recall why you were asking Mr. Bentley to provide information both on the definition of IV pharmacies and the findings of states' analyses?

A. I would only say we were probably looking at ingredient cost at that time.

Q. Does reading this refresh your recollection at all about conversations you may have had with Mr. Bentley or others at Ven-A-Care?

A. No.

Q. And it has been almost ten years since you actually -- more than ten years since you faxed this. Is that right?

A. Yes.

Q. So, it's fair to say there are a lot of

communications you may have had with Ven-A-Care that you don't recall given the passage of time?

MR. FAUCI: Objection.

THE WITNESS: It is possible, yes.

BY MR. TORBORG

Q. And if we look at the charts that are on Bates pages 756 and 57, does it appear as though -- you did not prepare this document, right, the charts?

A. I did not.

Q. Does it appear as though --

A. I don't think I did.

Q. Do you recall receiving these charts?

A. No, I don't.

Q. Do you have any reason to believe that you did not receive them?

A. I don't recall. I really don't.

Q. But if you did receive these, does it appear as though you are being advised of the differences for certain drugs between the brand name AWP and what Louisiana Medicaid was purportedly reimbursing?

Q. Where should the profit be, in the dispensing fee or the ingredient cost?
A. I think that is dependent on how you structure your reimbursement methodology.
Q. It could come in, in your view, either way and not violate any law?
MR. FAUCI: Objection.
THE WITNESS: Well, I think CMS charges you to have a reasonable reimbursement, so whether you pay low on the dispensing fee side and you put your profits on the ingredient cost side, or vice versa, they have a final say on approving that.
BY MR. TORBORG
Q. Has there been tension between Louisiana and HCFA on where the profit should be, whether on the ingredient side or the dispensing fee side?
MR. FAUCI: Objection.
THE WITNESS: No.
BY MR. TORBORG
Q. If I could ask you to take out Abbott Exhibit 1051 again. It is this one here, the 1999 Myers and Stauffer report. In particular, I would

like to direct your attention to page 5 of the report, under "Summary of Findings." There is a footnote 1 at the bottom of the page that states, "The cost reported for pharmacies dispensing intravenous prescriptions is not representative of routine Medicaid prescription dispensing cost and therefore is excluded from this media."
Do you see that?
A. Yes.
Q. If we go to page 20 of the 1999 Myers and Stauffer report, on the ingredient cost and dispensing fees, pages 20 and 21, do you see there is additional discussion of the additional costs involved in dispensing IV prescriptions?
A. Yes.
Q. On page 20, the report notes "The most significant characteristic which affected pharmacy dispensing costs was the provision of intravenous solutions. Our analysis revealed significantly higher cost of dispensing is associated with the 28 pharmacies in the sample that provided this service."

Do you see that?
A. Yes.
Q. And the drugs that are at issue in this case that we saw in the complaint, those are intravenous solutions, correct?
A. Yes.
Q. If we go to page, the next page, page 21 of the report, there is a chart that calculates the unweighted mean total cost for pharmacies dispensing IV prescriptions and then pharmacies not dispensing IV prescriptions, right?
A. Correct.
Q. Cost being $18.57 for the IV prescription pharmacies, and $5.55 for the pharmacies not dispensing IV prescriptions. Do you see that?
A. Yes.
Q. Do you recall becoming aware of the fact that pharmacies which dispensed IV prescriptions had a higher cost to dispense?
A. I would say I was somewhat aware just because their setting is different than the normal retail setting.

Q. And this is something that Myers and Stauffer advised you of in this, correct?
A. Correct.
Q. And then at the bottom of the page, there is a footnote that says, "Although typical dispensing fees reimburse less than dispensing cost of IV pharmacies, they are generally able to break even based on the margin allowed on ingredient cost reimbursement."
Do you see that?
A. Yes.
Q. Do you understand what it is saying?
A. They are saying there is profit on the ingredient side.
Q. Was that something that you were aware of for the time period of 1991 through 2001, as the pharmacy consultant and pharmacy director in Louisiana Medicaid?
MR. FAUCI: Objection.
THE WITNESS: As stated in this document.
BY MR. TORBORG
Q. Well, did you become aware of the fact

that, in essence, the profit on the ingredient side was subsidizing insufficient dispensing fees?
MR. FAUCI: Objection.
THE WITNESS: I would say no, I was not -- I had an understanding of it, but I did not know it until they documented it.
BY MR. TORBORG
Q. And Louisiana did not have a separate dispensing or -- dispensing fee or compounding fee for home IV providers. Is that right?
A. Correct.
Q. Some states did, correct?
A. Yes.
Q. Why didn't Louisiana?
A. I would say the secretary at the time was interested in formulating a discount in totality on ingredient costs and dispensing fee across the board.
Q. Was consideration of the profit being made on the ingredient side a factor in not increasing or providing a separate fee for home IV services?

A. I don't know the answer to that.
Q. Well, here you are told in this document that Louisiana is not paying a dispensing fee that is anywhere close to the cost of dispensing found by Myers and Stauffer for home IV prescriptions. Is that right?
A. Yes.
Q. So, fair to say that you were underpaying those pharmacies?
MR. FAUCI: Objection.
THE WITNESS: Based on the report on the dispensing side.
BY MR. TORBORG
Q. What do you mean by "on the dispensing side"?
A. On the dispensing cost side.
Q. How about on the ingredient cost side?
A. Well, based upon what is stated here, it looks like they were getting a margin on the ingredient cost side.
Q. So, if someone wanted to determine how much Louisiana Medicaid overpaid pharmacy providers

for providing home IV drugs to Medicaid beneficiaries, would the uncompensated higher cost to dispense home IV prescriptions be something you would look at?
MR. FAUCI: Objection.
THE WITNESS: I would say we paid it in accordance with our state plan.
BY MR. TORBORG
Q. But if you were looking at the situation today, as an informed observer who was there at the time from 1991 to 2001, and you were asked to determine how much Louisiana Medicaid overpaid, if at all, providers for dispensing home IV solutions, would you consider Myers and Stauffer's findings that there was a much higher cost to dispense?
MR. FAUCI: Objection.
THE WITNESS: I would say we did not overpay. We paid it in accordance with our state plan.
BY MR. TORBORG
Q. So, you would say any payment consistent with the state plan is not an overpayment. Is that right?

MR. FAUCI: Objection.
THE WITNESS: I would say you have to look at it, do a survey, conduct a survey and resubmit your state plan.
(Exhibit Abbott 1062 was marked.)
MR. TORBORG: For the record, what I have marked as Abbott 1062 is a series of e-mails, most of which or all of which are copied to Ms. Terrebonne and others, KYDMSPL-0111755 through 809.
They were produced to us in connection with another litigation. That's my understanding.
BY MR. TORBORG
Q. Ms. Terrebonne, were you on an e-mail list that included other state pharmacy administrators?
A. Yes.
Q. What was that called?
A. What was the e-mail list called? I don't know what it was called. Probably the National Pharmacy Benefits Association -- the National Pharmacy --
Q. Not Medicaid Pharmacy Administrators, or

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something like that?
A. Yes.
Q. When did you start on that e-mail distribution?
A. Oh, it's been several years.
Q. Do you still have those e-mails on your computer?
A. I have some e-mails.
Q. Now, this collection of documents was produced in sequential order. All appear to be different e-mails concerning reimbursement for compounding home IV-type issues of the type we were just talking about. I would like to ask you to go to the Bates page ending 768. Are you there?
A. Yes.
Q. The bottom of the page is an e-mail from Rachel Broussard. She was on your staff?
A. Yes.
Q. Is on your staff?
A. (Witness nods head affirmatively.)
Q. She e-mailed a distribution to the state Medicaid administrators; is that right?

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A. Yes.
Q. Do you recognize those names?
A. Yes.
Q. And she asked, "We are interested in information regarding policies in reimbursement of compound prescriptions. Are other states reimbursing pharmacy providers for compound prescriptions? If so, what is your policy for reimbursing compounds, what is your reimbursement methodology and do you reimburse a compound fee?"
Do you see that?
A. Yes.
Q. Do you recall Ms. Broussard seeking information from other states concerning reimbursement of compound prescriptions?
A. Yes.
Q. What motivated that? Was it the Myers and Stauffer report?
A. No. Occasionally, we will get calls on compounding scrips, and we don't have any policies so we were looking at other states' policies.
Q. Do you know what, if anything, Louisiana

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did with the information it received?
A. We haven't done anything yet.
Q. Why is that?
A. Probably because we have lots of other things to do, so it is still on our to-do list.
Q. If reimbursement were cut on the ingredient side, the actual acquisition cost, is that something you think would go to the top of your list and re-create a separate fee for compounding?
MR. FAUCI: Objection.
THE WITNESS: I don't know, it's a kind of whatever-is-on-top-of-the-list sort of day here.
BY MR. TORBORG
Q. And what runs the agenda on what is at the top of the list?
A. The secretary of the department.
Q. And the secretary of the department gets calls from providers?
A. Yes. Mostly we get calls from providers.
Q. Do you recall getting phone calls from providers concerning the need for a compounding

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fee?
A. We have gotten a few calls, yes.
Q. Do you recall what you have told them about why it is Louisiana is not paying one?
A. Rachel answers those calls primarily. We try to work with the pharmacist to, under our existing policy, to go ahead and provide those drugs.
Q. Well, how about the payment of a separate higher dispensing fee for compound prescriptions?
A. That has not been addressed.
Q. Okay. If I could ask you to get out Abbott Exhibit 292, which is one of the -- should be on the top right underneath the stack there. I think I put it in order. This is a document titled "Medicaid Pharmacy Bulletin," dated January/February 1997, titled "Medicaid Reimbursement for the Pharmacy Component of Home IV Therapy."
Do you see that?
A. Yes.
Q. And you recall getting these bulletins.

Is that right?
A. Yes.
Q. And you were at some point a member of the editorial staff. Is that right?
A. Yes. For a short tenure.
Q. And did you retain copies of these bulletins?
A. I don't believe I have them anymore.
Q. If I wanted to get my hands on these, what is the best way to get them, other than the ones I have? If I wanted to get all of the copies of these, what is your -- do you have any guidance for me about how I might do that?
A. I do not, other than you would get a pharmacy director that retained them all.
Q. Was it your understanding that this was a publication that was widely recognized in the state Medicaid pharmacy administrator universe?
A. Yes.
Q. And do you recall when you were on the advisory panel of this publication, that there were annual meetings that were associated with this

publication?
A. I do not recall.
Q. I would like to ask you to go to the second page of Abbott Exhibit 92, under the Section 1, "The Development of Pricing Mechanisms for Home IV Medications," it states, "The establishment of a fair and reasonable pricing methodology for home IV products is a major concern of most state Medicaid programs. One of the major obstacles to the development of adequate home IV pricing methodologies is the fact that the dispensing of home IV medications is more complex than the dispensing of other outpatient drugs."
Do you see that?
A. Yes.
Q. And was that something that you were aware of throughout the time 1991 through 2001?
A. I do not recall.
Q. Do you recall when you started receiving these bulletins?
A. I do not.
Q. Do you have any basis to disagree with

the notion that dispensing home IV medications is more complex than dispensing of other outpatient drugs?
A. I agree it is more complex.
Q. Let me ask you to go to the next page. We are on page 390. It says, "Providers and pharmacist consultants concur that it is not appropriate to apply the same ingredient-based pricing mechanisms to home IV medications as those that apply to other outpatient drugs."
Do you see that?
A. Yes.
Q. Did you agree with that?
A. I don't know that I agree with it. I would say you would have to survey to determine what is the appropriate structure of the pricing mechanism that you utilize for home IV, although it should probably be different than normal retail business.
Q. And if we go to the second paragraph under that section, it states, "Home IV treatments are frequently a combination of multiple drug

entities dispensed in varying doses and dispensed several times daily. Although it may be minimal to moderate in quantity over an entire treatment, large volumes of medications are generally administered. It is therefore difficult to estimate based on a single daily or even weekly administration the purchase price these providers are paying with volume and trade discounts. These discounts are generally not revealed in drug publications such as Red Book, Blue Book, and DataBank. Consequently, programs are reluctant to increase reimbursement for home IV medications, suspecting that reported costs for these substances may already be exaggerated."
Do you see that?
A. Yes.
Q. Do you have an understanding of what that last sentence is saying?
A. What I think it is saying is that the programs -- and that would be the Medicaid programs -- are reluctant to increase the reimbursement for home IV based upon the increase in cost of the

ingredients for those substances.
Q. Was that consistent with the experience in Louisiana?
MR. FAUCI: Objection.
THE WITNESS: I do not recall that.
BY MR. TORBORG
Q. May have been, but you don't recall?
A. I wouldn't know without doing an analysis, which I did not do.
Q. Are you familiar, Ms. Terrebonne, with something called findings and assurances under the federal regulations for reimbursement of prescription drugs, under the federal regulations?
A. There are assurances. I believe you submit a letter to CMS assuring that you will adhere to your state plan.
Q. If I could ask you to go to Abbott Exhibit 284 in that same binder there. This is a copy of a federal regulation. In particular, I would like to ask you to go to the last page of the exhibit. The second column, "447.333, State Plan Requirements, Findings and Assurances." Do you see

that?
A. Yes.
Q. Under "B, Findings and Assurances," it states, "Upon proposing a significant state plan change in payments for prescription drugs and at least annually for multiple source drugs and triannually for all other drugs, the agency must make the following findings and assurances."
And it lists that and goes on. Are you familiar with this regulation?
A. Somewhat. I haven't seen it in a while.
Q. Do you know if Louisiana, when was the last time Louisiana provided the annual findings and assurances for multiple source drugs?
A. I do not.
Q. Is it something that you think you would be familiar with if it was done?
A. The policy section, our policy section would submit that to CMS.
Q. Do you recall Louisiana, in the period 1991 to 2001, providing the findings and assurances called for in 477.333?

A. I would answer that saying yes, I have seen that within that time period.
Q. At some point in that time period, did that quit happening?
MR. FAUCI: Objection.
THE WITNESS: I don't know. I don't know.
BY MR. TORBORG
Q. Well, are you doing them today?
A. I am not doing them today.
Q. Do you know of anyone who is?
A. I don't know.
Q. Who would know whether or not Louisiana is doing that today, providing those findings and assurances called for by the statute?
A. Probably someone in our policy section.
Q. If I could ask you to go to Abbott Exhibit 137. This is a letter dated February 16, 2000, from the office of Attorney General, Medicaid Fraud Control Unit, State of New York, from Patrick Lupinetti. Also at the top are Elliott Spitzer and Jose´ Maldonado. This is to a pharmacy director in Cheyenne, Wyoming. Take a look at that document,

Ms. Terrebonne, and let me know if you are familiar with this type of document.
Ms. Terrebonne, do you recall this type of document?
A. I recall some of the names but I don't recall the document.
Q. Which names do you recall?
A. Mary Reardon, Caroline McElroy.
Q. Do you recall those individuals making a presentation at a national conference of state Medicaid personnel about this topic of using revised average wholesale prices?
A. I don't recall.
Q. Do you recall that an effort was made in 1999, 2000 and 2001 time frame where the Department of Justice spearheaded an effort to get new information on certain injection, intravenous and inhalation drugs?
A. I know they were involved in something to do with that, yes. I recall reading it.
(Exhibit Abbott 1067 was marked.)
MR. TORBORG: For the record, what I have